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FOR CONTENTS SEE PAGE VII.

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ST. LOUIS, MO., APRIL, 1899.

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ORIGINAL COMMUNICATIONS.

(Original communications are received with the understanding
that they are contributed exclusively to THE LARYNGOSCOPE.)

REMARKS ON THE ETIOLOGY OF NASAL POLYPI.*

BY JONATHAN WRIGHT, M.D., BROOKLYN, NEW YORK.

About two years ago a girl sixteen years old came to one of my clinics with the history of left-sided nasal obstruction. Her family history was good. She was anemic in appearance although she stated that she was and had always been in good health, having never had any illness of any kind. She was a rather stolid, stupid appearing girl. She had begun to menstruate when fourteen years old, and from the first had always been perfectly regular with no appreciable nervous disturbances. She thought that she first noticed the left nasal obstruction about six months before coming for treatment. Through the right nasal fossa a mass could be seen apparently completely blocking up the choana posteriorly though she could still get some air through that side. The left nostril was blocked with moderate sized polypi, which were subsequently found to be springing from the large one in the posterior part of the nose. This edematous globular mass was seen to almost entirely fill the nasopharynx. The small nasal polypi were gradually removed from the left nostril, but all attempts to encircle the large tumor either through the right or left nostril with the wire loop of a snare were unavailing. Attempts were made to seize the growth with forceps through the nasopharynx, but only small shreds could be removed in this manner.

*Read before the Laryngological Section, New York Academy of Medicine, Feb., 1899.

The patient was finally put under ether and an attempt made to use the snare, but it was again found impossible to do so because the growth so completely filled the nostril. It was found that by forcible manipulation with the finger in the naso-pharynx portions of the surface would give way with the escape of watery fluid. In this way the size of the tumor was reduced over one-half in volume and to such an extent that it could be almost entirely pushed into the left choana, but the growth still eluded the wire loop. Further attempts were postponed until the next day, when, without ether, no difficulty was experienced in removing the tumor from the nose with the snare.

During all these maneuvers the loss of blood was very trifling. The tumor in its reduced dimensions was about the size of an English walnut and its surface was lobulated, each lobule proving to be a cyst cavity. It was then seen that the growth had sprung by a small pedicle from the middle of the convex surface of the inferior turbinated body about 1 c. m. from its posterior border. There was considerable reaction from the violence of the operative procedures, but this soon subsided. At the end of ten days it was seen that a small edematous polypus, the size of a bean, had formed at the site of the attachment of the former tumor. The mucous membrane elsewhere in both nostrils appeared perfectly healthy. There was no evidence of any sinus suppuration. There was a very small amount of adenoid tissue in the naso-pharynx. The recurring polyp was removed, and in three weeks time another had formed and was removed. At intervals of two to four weeks, for nearly a year, polypi, usually single, formed at approximately the same spot. They were never suffered to become large enough to cause any difficulty in the removal, but it was evident that left unmolested they would have quickly grown to the dimensions of the first tumor. The patient was put on iron and other tonics and the small amount of lymphoid tissue removed from the naso-pharynx. The surface from which the polypi grew was cauterized several times. Nearly all of the polypi contained cysts, and many of them seemed to be nothing more than blebs, which would burst and collapse when the snare was tightened, or even simply from the contact of the wire. Gradually they ceased to recur, and it has now been more than six months since one has appeared. The general health of the patient has remained good from first to last.

Nearly all the material removed was examined microscopically. Uniformly the structure was covered by columnar epithelium and was made up of extremely dilated meshes of connective tissue filled with coagulated fibrin. There were no glands and no blood vessels except

a very few small capillaries. All the cyst cavities were formed by the breaking down of the scanty stroma and the coagulated fibrin strands. The spaces thus formed were irregular, and the walls were the ragged ends of fibrin and a few connective tissue fibers. This was true not only of the cyst cavities of the large mass first removed, but also of the small recurring buds, many of them being apparently only effusions of serum beneath the surface epithelium.

You will perceive that this case presented some unusual features. It is perhaps not devoid of significance in itself that so many exceptions to the usual phenomena are noted in the one case. While we are accustomed to observe the posterior ends of the hypertrophied inferior turbinated bodies become edematous, it is exceedingly unusual to find springing from the surface of this erectile tissue a large pedunculated edematous polypus which in structure presents no resemblance to the bulk of the vascular tissue beneath. At least in my experience this, so far as I remember, is unique. Less exceptional is the age of the patient, although it is very unusual to see edematous nasal polypi in any situation at the age of sixteen. It will be well to bear in mind, in view of what I have to say further on in my remarks, that this tumor may be supposed to have begun its growth shortly after the advent of puberty. The recurrence of nasal polypi after removal is the rule rather than the exception, especially when their place of attachment is near the hiatus semilunaris in purulent disease of the accessory sinuses. We are not accustomed, however, to see them recur with the rapidity they showed in this case after removal, which could be plainly seen in the post nasal mirror to have been radical. They seemed to spring up in the night.

The structure was also exceptional. In the back part of the nose there is usually more fibrous tissue in the polypi than in those growing anteriorly. This is not only observed microscopically but appreciated clinically. In this growth, however, the fibrous stroma was exceedingly scanty and over large areas very little could be made out, the coagulated fibrin being almost entirely unsupported. This was evidently the explanation of another unusual phenomenon. The usual origin of cystic cavities within edematous polypi is the gradual dilatation of a racemose gland whose conduit has been occluded and whose walls continue to secrete fluid. A few authors have described cyst cavities in nasal polypi as arising from the wide separation of the stroma fibers by serum and the subsequent breaking down of the coagulated fibrin. While I have seen such areas under the microscope they have nearly always hitherto been of minute proportions or of such an appearance as has led me to presume that they were the

result of the hardening and cutting process incidental to preparation for microscopical examination. In this case, however, not only were many minute spaces plainly visible under the microscope, but very large cavities were seen by the naked eye to exist in the fresh polyp, and their rupture was necessary to reduce the size of the growth before removal. I think I mentioned a case before this section of an apparent cyst of the larynx, which, when it had collapsed, was seen to have sprung from an edematous syphilitic infiltration of the subjacent structures. In all probability this was a cyst cavity formed in the manner described above. It will be noted that not only was the original nasal tumor largely made up of these cavities, but the later recurring buds were almost entirely occupied by them.

I have enumerated these exceptional features, not so much with the idea of being able to advance any adequate explanation as because of the hints they give of previously studied and apparently dissipated problems. The scientific world has long grown accustomed to look askance at theories. In fact, we sometimes carry the Baconian philosophy so far as to think that we have no use for theories at all and that they should be rigidly excluded from our thoughts as well as from our logical premises. The modern hunger for facts and its neglect of theories is sufficiently obvious. The Athenian philosopher in his tub and the modern myope with his microscope and test tube are the antipodes of intellectual activity—and of the ridiculous. But, after all, we can no more dispense with theories than we can with facts. Facts are infinite in number. Groping among them at random is a folly that leads nowhere. We must, to some extent, formulate our theory first and then select the facts to support it. If subsequent investigators produce facts which demolish it, well and good, the facts remain. The real harm of theories is that after awhile they are regarded as facts and facts are not accepted because they interfere with theories.

A working theory is as necessary in many of the problems of nasal pathology as in other and broader fields of scientific labor. I have recently had occasion (*N. Y. Med. Journ.*) to refer to the work of Cholewa and Cordes, who, after demonstrating the histological bone changes which take place in atrophic rhinitis, advance the theory that these bone changes antedate the changes in the mucosa and are the cause of them. They liken the bone changes here to those occurring in osteomalacia, saying that the absorption of the inferior turbinated bony structure is due to the continued activity of the osteoclasts in their bone absorption while the osteoblasts have lost their power of bone building. As I have pointed out elsewhere (*Am. Journ. Med.*

Sc., May, 1895), the blood supply to the mucosa is regulated by radicle arteries and veins which lie in bony canals. This is especially true of the excessively vascular tissue of the inferior turbinated bodies. Any process therefore which disturbs these bony canals and their contents must be supposed to exert a marked influence upon the nutrition of the mucosa covering the bone. Hence the theory that there is a primary bone disease in atrophic rhinitis furnishes a plausible explanation of the changes in the mucosa with their attendant symptoms. Now, this attractive superstructure rests upon the assumption of the authors that the bone lesion antedates that of the mucosa. So far as I have been able to see, there are no direct observations reported which establish its validity, but so long as there are no facts which controvert their statements we may be allowed to entertain the theory. It may be remarked in passing that this only moves back by one step the mystery of the disease so long as we fail to account for the origin of the bone trouble.

Now let us bear in mind some of the work of Dr. Woakes, of London, which has been subjected to such severe criticism by many writers in rhinology. In previous papers I have combated many of his statements, but I am now free to confess that in doing so I have overlooked much in his work of which subsequent observation has proved the value. His contention that the bone lesion of the middle turbinated is the primary one in the formation of edematous polypi makes a striking parallel to the theory of Cholewa and Cordes in regard to atrophic rhinitis. Here again there are doubtless many cases in which it is impossible to controvert the assumption by direct observation, but while it is impossible to deny that in some cases the process may have begun in the bone, that is certainly not the rule. Edematous polypi not only frequently spring from mucosa which covers perfectly healthy bone, but frequently also from a mucosa with no underlying bone at all. However, in order to fix in our minds these assumptions of the different authors as to the analogous origin of two different nasal pathological conditions let us reduce them to their simplest terms, for they are sure to be of value in the future study of nasal pathology although they may not finally be accepted as essentially true.

"Bone changes in the inferior turbinate by obstructing the blood supply diminish the nutrition of the parts and thus cause atrophic rhinitis." (Cholewa and Cordes.)

"Inflammation of the spongy bones leads to the formation of edematous polypi." Woakes called the latter myxomata, but this nomenclature has of late years been abandoned. Although Woakes

does not explain how the bone lesion produces the condition in the mucosa which he calls myxoma we may, if we admit the antecedent bone lesion, suppose that it is due to the obstruction of the radicle veins in the bony canals. But as I intimated above we certainly are not able to adduce this cause in many cases.

Nevertheless, in edema of the mucous membrane, we must presume that there is some change in the blood vessels permitting of the transudation of the watery parts of the blood. We know that in certain localities of the body obstruction to the venous circulation causes edema of the tissues or the effusion of serum into closed cavities. While edema of the glottis is not unknown in cardiac, renal and hepatic disease I have never heard that these obstructions to the systemic venous circulation ever cause any edema of the nasal mucosa. We cannot exclude so positively the local obstructions due to inflammatory changes either in the mucosa or its underlying stroma and bone. Although in many previous communications I have stated my belief that edematous polypi are the result of chronic inflammation it is very evident that this assertion only partly explains the phenomenon, because in many cases even where the polypi spring from the middle turbinated region, as well as in this case where it sprang from the erectile tissue of the inferior, the other evidences of inflammation are absent. Here as elsewhere we must not be misled by an attempt to simplify etiology by seizing exclusively on one factor. There is not the shadow of a doubt that the changes produced by inflammation play a very important role in the etiology of the growth of edematous nasal polypi, and yet it is quite as evident from clinical observation that in some cases the nasal mucosa does not present any marked signs of chronic inflammation. Moreover there is not satisfactory evidence that the occurrence of the polypi or of edematous infiltration bear any direct proportion to the severity of the inflammatory condition in cases of chronic rhinitis. It is therefore necessary for us to seek further explanation and not depend exclusively on the mechanical obstruction produced by the inflammatory deposits.

A great deal has been said as to the influence of nasal lesions as an important factor in the causation of hay fever and bronchial asthma. It is undoubtedly true that in a number of cases of hay fever nasal polypi will be found to coexist. During an attack of hay fever it will be seen that the nasal mucosa is reddened and swollen and often edematous. When the paroxysm is over the congestion and edema often entirely disappear, but not infrequently it will be found that the mucosa has been left in a waterlogged condition, or if

there have been nasal polypi present during the attack they still persist. Now, it has nearly always been my experience to find on going into the histories of these cases of hay fever or bronchial asthma with nasal polypi that the obstruction of the nostrils due to the polypi has begun after the hay fever has existed for several seasons. It is true that this is not always the case, but I have noted it often enough to have the query arise in my mind whether the hay fever has not caused the polypi, quite as frequently as the presumption that the polypi have caused the hay fever, and I have finally come to believe that neither of these interpretations is the correct one, but that the two phenomena depend to a large extent upon a common cause. It is quite in accordance with the usually accepted doctrine to say that I believe this common cause is to be found in the sympathetic nervous system and more immediately in the vaso-motor nerves.

Let us now return to the consideration of inflammation. What is inflammation? When one tries to define it in its histological sense the answer is long and involved, and, to tell the truth, not always satisfactory. Without, therefore, entering upon the definition it will suffice for the purpose here in view to say that a part of the process is at first a spasm and then a paralysis and resultant dilatation of those smaller blood vessels, both venous and arterial, which have muscular coats; and that this abnormal action is due to the excitation of the vaso-motor nerves which govern the muscles regulating their caliber. This disturbance of the functions of the vaso-motor nerves is an essential factor in the process of inflammation, but the process of inflammation is not necessarily a sequence of the disturbance of the functions of the vaso-motor nerves. There is every reason to believe that it is this dilatation of the blood vessels which is also one result of the sympathetic nerve storm which we call hay fever. Transudation of serum from the vessels into the tissues we know to be one result of vascular dilatation. The radicle arteries and veins lying together in the same bony canal cannot both dilate equally. The wall of the artery being both more muscular and less compressible than that of the vein it must necessarily follow that the lumen of the vein is compressed, and hence the outlet of blood from the mucosa is hindered although the ingress of blood from the dilated arteries is greater than normal. We have thus a plausible explanation of the greater frequency with which a mucosa lying close to the bone in the region of the middle turbinate becomes infiltrated with serum than does the mucosa of the mouth for instance or that of the stomach. Now, in the vascular region of the nose, which is par excellence the inferior turbinated body, we have the surface capillaries

separated from the bone by an underlying network of venous sinuses. It is in this region especially that edematous nasal polypi are so rarely seen. I cannot hope that you have followed my paper closely enough to render a recapitulation unnecessary. If the observations I have here detailed and the deductions which have followed are correct we may sum them up by saying:

Edematous infiltration of the nasal mucosa either sessile or in the form of polypi may result:

First, from mechanical obstruction to venous return by the products of inflammation in the mucosa or in the underlying bone;

Or, second, from the vaso-motor phenomena accompanying chronic inflammation;

Or, third, from the vaso-motor phenomena present in neuroses which may give rise to hay fever and bronchial asthma.

Let us now see how these ideas in regard to the etiology fit in with the report of the exceptional case with which I have prefaced my remarks.

First, as to the age: The growth began shortly after the advent of puberty when the sympathetic nervous system is apt to be unusually disturbed. In this particular case there is absolutely no evidence of such disturbance. The situation, upon the inferior turbinated, its persistent recurrence and the rapidity of the growth on the other hand argues against the assumption of causation by the mechanical obstruction of chronic inflammation. Moreover, there was no macroscopic evidence of the presence of inflammation to any marked degree. Its strict localization to one spot, the rapidity of its growth and recurrence, and the peculiarity of the bleb formation of the later recurring buds, they being nothing more, as stated in the history, than localized effusion of serum beneath the epithelium, all these are irreconcilable as far as I see under any other supposition than that contained in the third formula; viz., that there was in this case some sharply localized vaso-motor disturbance which led to the rapid effusion of serum from the vessels.

Whether this is the true explanation or not you will agree with me that such a case should not be allowed to pass across the path of our clinical experience without careful study of the problems it presents. Possibly by such means we may hope to eventually elucidate puzzling questions in etiology and pathology, because we may presume that in the exceptional cases many non-essential factors have been eliminated from the etiology, and many confusing coincidences from the pathology.

A SIMPLE METHOD OF PREPARING A SERVICEABLE SOLUTION OF THE SUPRA-RENAL GLAND FOR NASAL OR LARYNGEAL APPLICATION.

BY M. D. LEDERMAN, M.D., NEW YORK.

Lecturer on Diseases of the Nose and Throat, New York Polyclinic; Assistant Aural Surgeon, Manhattan Eye and Ear Dispensary; Fellow New York Academy of Medicine and American Laryngological, Rhinological and Otological Society, Etc.

The desiccated extract of the supra-renal gland of the sheep has undoubtedly established a permanent position for itself in the therapeutic armamentarium of the rhinologist. Bloodless operations upon the nasal septum are now an actual fact, and the "fear-of-blood" sentiment, so often expressed by neurotic patients, can be conscientiously subdued, with the reassuring statement, that the operation can be performed with the demonstration of but little if any blood. There is one disadvantage of the watery solutions of the desiccated gland, and that is their tendency to rapidly become putrid and unfit for use. The addition of antiseptics undoubtedly retard putrefaction, but at the same time unfortunately interfere with the hemostatic properties of the gland. For the past few months I have been experimenting with formalin, carbolic acid, corrosive sublimate and boracic acid, and have found that in solution they all prohibit the marked vaso-constricting action of the gland.

To overcome this rapid tendency to decomposition the writer has followed the suggestion of Dr. C. Fisch, of St. Louis, and employed a glycerine solution with satisfactory results. Glycerine being somewhat antiseptic, is sufficiently active in a twenty-five per cent watery solution to prevent the putrefaction for some time, without retarding the physiological action of the gland. In this strength the solution is not too viscid, and can be applied in the form of a spray, if so desired. My custom has been to apply the "glycero-watery extract" by means of cotton applicators, both before and immediately after the application of cocain. In this manner, constitutional symptoms of cocainism can be avoided. Two or three applications of the supra-renal extract will prove sufficient. After its use, the swollen mucous membrane rapidly assumes a contracted appearance, and an ischemic condition exists.

We now perform the operation, and we are agreeably surprised to find the field unobstructed, and but little, if any blood in the nose.

A word of caution will not be out of place. Reaction does follow in a number of instances, and it is always judicious to employ a nasal plug for about twenty-four hours over the site of operation.

A tampon of nosophen gauze will prove antiseptic and at the same time keep the wound dry, a peculiar property of nosophen. Other antiseptics may be employed in a similar manner. The writer has been in the habit of using a tampon of "spunk" cut into suitable shape, and dipped into nosophen powder. This substance possesses the advantage of coming away smoothly from the wound, and thus avoiding secondary bleeding. Specially is it of service in cases where the turbinates are in close proximity to the septum. If properly dusted with an antiseptic powder, the "spunk" may be allowed to remain in the nose for forty-eight hours or longer. It is quite porous and promptly absorbs moisture, increasing in size when active, and by its own bulk causing direct pressure, thus acting as a hemostatic. The smooth soft variety is most serviceable.

The solution of the dessicated extract of the supra-renal gland mentioned above is made as follows: About ten (10) grains of the gland (Armour's) is employed to the drachm of a twenty-five (25) per cent glycerine-watery solution. A half or an ounce of this mixture is placed in a wide-mouthed bottle, and well shaken. It is then allowed to stand in the room at the ordinary temperature (68° F.) for about forty-eight or fifty-two hours. During this time the bottle is occasionally shaken. The mixture is then permitted to filter through the ordinary filter paper into a clean bottle. We will then have a slight amber-colored solution, which is ready for use. It is advisable to employ a small quantity of the "extract-solution" at each sitting. In this manner the remainder of the solution, if placed in a cool atmosphere, will keep clear for some time.

38 East Sixtieth Street.

ON AGORAPHOBIA IN RELATION TO EAR-DISEASE.*

BY PROF. A. GUYE, AMSTERDAM.

Agoraphobia is a neurosis consisting in a fear or anguish to cross any larger or smaller open space. It is well known to the neurologists and psychologists since the description given of it by C. Westphal in 1872.†

Not long before him P. Benedikt‡ had described a few cases of the same kind under the name of "Platzschwindel." According to Benedikt, they stood in relation to a form of vertigo, caused by insufficiency of some eye muscles, especially the recti interni. Westphal and other authors who described cases of agoraphobia afterwards did not find this cause existing in their patients.

Legrand du Saulle§ then described a number of cases, and considered them as a form of neurasthenia, sometimes produced, according to him, by abuse of coffee.

E. Cordes,|| in the same year as Westphal, published twenty-nine cases, and in a later paper, in 1880, fifty-four new cases. He also considers agoraphobia as a symptom of "reizbare Schwäche," or a neurasthenic anguish, which is caused by exhaustion, by intellectual overwork, by sexual excesses, chronic gastric disturbance, or, in some cases, by the successful cure of obesity.

The neurologists and psychologists seem till the last time not to have noticed the relation of agoraphobia to ear-disease. The first who have done so, to my knowledge, are Lannois and Tournier in Lyon,¶ who published, a few months ago, ten cases of agoraphobia, in which various forms of ear-disease seemed to be the cause of the neurosis. They admit, of course, that there must be a neurasthenic disposition, but, according to them, this disposition existing, the cause of the special form of anguish, which we call agoraphobia, very often is some disease of the ear which causes subjective sound-sensations and vertigo.

*Read by title at the Fourth Annual Meeting of the Western Ophthalmological and Otolaryngological Association, New Orleans, Feb. 10, 1899.

† *Archiv fuer Psychiatrie*, III, 138, 1872.

‡ *Allg. Wiener Med. Zeitung*, 1870, No. 40.

§ *Etude clinique sur la peur des espaces, névrose émotive*, Paris.

|| *Arch. fuer Psychiatrie*, III, p. 521, 1872, and IX, p. 48, 1880.

¶ *Lésions auriculaires cause d'agoraphobie. Annales des Maladies de L'oreille*, Paris, October, 1898.

In some of their cases there was purulent catarrh of the tympanum with perforation of the membrane, in others sclerosis, in one typical Menière's disease. In three cases they saw the agoraphobia disappear after the successful treatment of the ear-disease, and they think that would be more generally the case if the ear-disease itself were not in many cases so intractable.

I have a case in observation since 1880, whose history is, in short, as follows:

Miss X (M. 55), age thirty-three, who was and is still at the head of a large school, came under treatment in December, 1880.

She complained of slight deafness in her right ear since half a year; since two months she had ringing in that ear and now and then some giddiness at rising in the morning. But since two years she complained of agoraphobia, and was not able to go out alone. There was marked swelling and narrowness of the Eustachian tube on that side, chronic nasal catarrh, mouth-breathing, etc. Under treatment the condition of the ear was much improved, and only the agoraphobia remained. Since then there came frequent relapses, sometimes with very marked symptoms of Menière's disease, falling down, vomiting, etc. Under local treatment, and also under the influence of salicylate of soda (0.50—1 gramme twice daily), these symptoms generally subsided in a few weeks, but even when she had been for a year or longer without any vertigo or giddiness, the agoraphobia remained unaltered, and she is never able to go out alone. She does not fear an attack of vertigo, but she has the unexplained anguish to cross a place or street.

A remarkable feature in her case, which has also been noticed by some other authors in some cases, is that when in the country in her holidays she has sometimes been free of agoraphobia and been able to walk about alone for a few days, which she never is when in town. It may be that the frequent movements of the head in looking to the right and left, to which one is obliged in the busy streets of the town, produce slight rotatory sensations which unconsciously may influence the feeling of anxiety.

One other observation which she has made seems worth recording, that is, that after taking a few glasses of wine, being at a watering place with friends, she for the moment felt that she was nearly free of her complaint. Very rightly she did not wish to make use of this symptomatic means. Cordes (l. c.) also mentions the temporary benefit produced by wine in some cases. I have also observed the same in some cases of chronic Menière's disease, but would not, of course, advise it, as the danger of inducing alcoholism would be very great.

I have seen another case of a gentleman where very marked agoraphobia had existed for at least a year before he came under treatment for an acute middle-ear disease. This was successfully treated, but the agoraphobia remained. I can give no further particulars of this case, as the patient died a few years later without my having seen him in his last illness.

My observations in regard to this subject are limited to these two. I do not think that they throw much light on the subject, but nevertheless I thought it worth while to draw your attention to it, in the hope also that psychologists, when they see cases of agoraphobia, which I am sure they do now and then, will pay attention to the state of the ears, and by publishing their observations will promote the co-operation of men who cultivate different parts of the medical science.

The Semiologic Value of Hemorrhage from the Ears—TILLAUX—

Journ. des Méd. et de Chir., September 10, 1898.

After a traumatism, such as a fall from a high place, or a fall upon the chin, otorrhagia may be due to the following conditions:

1. When there already exists an inflammatory lesion of the tympanic cavity.
2. When there is a fracture of the external auditory canal.
3. When there is rupture of the tympanum.
4. When the base of the brain is fractured.

In addition to these, a history of the case and the general condition form a valuable aid in making the diagnosis.

SCHEPPEGRELL.

A New Method of Mobilizing of the Stapes—FARACI—*Archiv. Ital.*

di Otol., etc., VII. 4.

After describing the advantages of this procedure, the author advocates the mobilization of the stapes by a method which enables the operator to leave undisturbed the ossicular chain. A myringectomy is first made and then resection of the external wall of the *aditus ad antrum*. After the operation the tympanic flaps are replaced. The author prefers an instrument similar to those used by oculists for extraction of cataract, with such modifications as are required by the character of the case. He reports two cases with satisfactory results.

SCHEPPEGRELL.

MASTOID OPERATIONS.*

BY W. F. COLE, M.D., WACO, TEXAS.

It was before this Association, one year since, that I made my report of mastoid operations by means of the dental engine, using cocaine as an anesthetic. At the last meeting I presented before you a patient on both of whose mastoids I had operated. I had intended to present before you again to-day the same patient, who has made complete recovery, but unforeseen circumstances prevent.



Figure 1.

I have here this patient, on whose left mastoid I did this operation about the 20th of December, 1898. This man had been suffering with mastoiditis on the left side for about a year, following an attack of la grippe. Although he has been a man of powerful physique, he had become unable to follow his occupation of engineer. He suffered with tenderness over left mastoid and whole side of head.

*Clinic and Report of Cases by Dr. W. F. Cole, before the Central Texas Medical Association, January 12, 1899.

The sterno-cleido-mastoid muscle was very tender from mastoid to sternum, and he constantly inclined his head to that side. No supuration had ever occurred in the ear, and the drum membrane showed little evidence of inflammation.

I diagnosed the case as necrotic condition of middle and lower mastoid cells, with possibly some involvement of antrum.

This is the fifth case in which I have operated in this way, and I feel confident that my method is destined to supersede all others. I have pleasure, therefore, in presenting this case before you, and will detail my method in full. I explained this operation in Atlanta in March last. I have since reported it to many physicians in London, New York, Chicago and other places, and so far as I can learn I am the first to do this operation in this way, that is by using the dental drill with cocaine as an anesthetic.

As I have already reported in papers, which have been published, my first operation was a matter of necessity, because the patient could not take a general anesthetic. A description of the operation upon this patient will, in a general way, do for all operations. This man sat upright in a chair. I injected a sterilized cocaine solution beneath the skin where I intended to do the operation. Attaching this cutting trephine (see cut) to the engine, I cut out a plug of skin

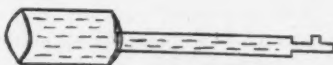


Figure 2. Cutting Trephine.

down to the bone instantly, this being the only painful part of the operation. Removing the plug of skin, I applied cotton, saturated with a solution of chromic acid with considerable pressure. This quickly checked the hemorrhage. I cleaned the bone of muscular tissue with the electric cautery. With a boring drill I perforated the outer table, making a small opening, after which I used a large dental burr. I am pleased to exhibit to you the instruments which I used. The whole operation with the engine took less than ten minutes, and the patient here will assure you that the operation was not more painful than ordinary dental work.

I found a condition in the mastoid cells resembling tubercle, which I curetted out carefully.

The probe passed readily into the antrum. On irrigation, the fluid passed readily down through the nose.

I used a bichloride solution for a few days, when I allowed the wound to close internally, keeping the external wound open as you see.

The patient has grown better from the first, and now, after twenty days, he is practically well.

The other cases which I have had all had suppuration of the middle ear, but as you see in this case I did not even break the drum, and the hearing was never seriously affected. I am delighted with this method of operating, not only because of the results, but because of its simplicity and safety. I did my first operations with much trepidation, but now I do the operation with as little hesitation as I do when I open up the superior maxillary sinus.

I regard the operation as not only more safe, but it has the advantages of doing no unnecessary damage to any part of the ear, and no unsightly scar is left. I feel sure that this operation will appeal to all rational aurists.

In order that you may contrast this method with the usual one, allow me to describe the operations as I saw them done in London during last summer. One hot evening in August I visited a celebrated ear and nose hospital, where I saw two operations done by what is known as the radical operation. The poor patient was put under complete anesthesia. A tremendous incision was made through the skin. The auricle was pulled forward, and skin separated from the bony meatus. The hemorrhage was profuse, keeping one assistant busy with sponges, while two held the wound open with retractors, and the principal proceeded with mallet and chisel to open the mastoid. When the cells were laid bare the whole of the posterior wall of the bony meatus was removed. The incision in the bone was then smoothed with a hand-burr with such force that I feared that the instrument would pierce the brain. Then the skin of the meatus and base of auricle was split posteriorly, the operator running his finger through the opening. The base of the auricle was pulled back, and stitched to the posterior part of the wound. I think I am correct when I say that five able-bodied men and a nurse were more or less actively engaged in this operation, besides one man to wipe the perspiration from the principal surgeon.

I have described this operation specially in order to emphasize the contrast. The description is in no sense a criticism upon the distinguished English surgeons, who as a class are not excelled in the world for ability and courtesy.

While the cure by means of the radical operation is said to be more assured, yet it has some serious drawbacks which should, in my

estimation, prevent its being done except as a last resort. A hideous deformity of the auricle necessarily results; the ossicles and membrana tympani are destroyed, removing all chances for the recovery of useful hearing.

I saw a number of patients attending the hospitals in London on whom this operation had been performed many months previously, and some of them complained bitterly that useful hearing had been destroyed, resulting in total deafness. I confidently predict that such operations will quickly be abandoned because they are irrational; and with it will also go the operation known as ossiculotomy, which has resulted in such an indiscriminate destruction of essential appendages.

With this paper is presented a photograph (figure 1) of the patient exhibited in the clinic. The picture was taken on the same day of the clinic.

A cut of the cutting trephine (figure 2) is also presented—natural size. This trephine may be obtained from Truax, Greene & Co. The kind of drill-handle should be stated.

Exophthalmic Goitre—A. SHAFFER—*Occidental Med. Times*, Vol. xii, No. 12, December, 1898.

The writer's own original ideas are described in this article. He holds that though exophthalmic goitre has primarily all the marks of a pure neurosis, and though the subsequent cardiac and abdominal disturbance soon become prominent, the thyroid is the dominant factor in this disease. He believes it probable that under a peculiar stimulus, the thyroid gland itself throws into the circulation enormous and toxic quantities of its normal secretion. That this secretion has a powerful effect on nutrition, and in large doses is capable of producing the most marked disturbance, has lately been repeatedly demonstrated. He thinks the opinion justified that the thyroid in ophthalmic goitre exhibits signs of increased functional activity as the result of pathologic examinations.

Myxedema is the antipode of goitre, as in the former we have a decreased or abolished secretion due to atrophy or ablation, there being enormous increase of interstitial tissue so as to completely or quite obliterate the secreting function of the gland. The mental and other symptoms in one disease are sharply in contrast with those of the other.

Should his theory prove correct, he believes the removal of the gland justifiable.

EATON.

TWO MASTOID OPERATIONS WITH UNUSUAL FEATURES.*

BY THOS. R. POOLEY, M.D., NEW YORK.

It is the object of this paper to briefly present for your consideration and criticism, two cases of mastoid operations, in which there were some unusual symptoms, occurring soon after the operation and in which the necessity arose to discriminate in their interpretation between the possibility of cerebral complication and other causes, and to point out the fact that there may be other solution, therefore, than the existence of the more often accepted ones, sinus thrombosis, cerebral abscess, either epi-dural or in the brain itself, through extension of the ear disease to the brain, and of less serious portent.

Case I—Mastoid operation, followed by vomiting, lasting for forty-eight hours, with subsidence thereof and subsequent good recovery.

On Wednesday, August 17, 1898, I was called to a distant summer resort to see a little girl of nine years. Early in July she had had an attack of acute follicular tonsilitis, from which she apparently made a good recovery, but about the middle of that month began to have symptoms of acute inflammation of the right middle ear, accompanied with very severe pain for a few days until otorrhea set in with temporary relief. From this time on until I saw her the history was one of transitory improvement with frequent relapses and recurring otorrhea. About ten days before I was called, a specialist whose summer home was near by saw her, but he did not take a very serious view of the case, nor suspect mastoid involvement, prescribed irrigations of the ear with hot bichloride solutions, but did not think an operation indicated. She was also seen by several specialists, in consultation with Dr. G. E. Munroe, the attending physician. According to the statement of this gentleman the swelling behind the ear came on only two days before I saw her, but she had had a considerable rise of temperature for some days before the swelling was noticed. When I saw the little patient on the evening of August 17 she was suffering from the most agonizing pain, which beginning behind the ear, extended to the occiput. It would be impossible to exaggerate the suffering she was undergoing. The otorrhea was not very profuse; there was great swelling of the posterior wall of the

*Read at a Meeting of the Eastern Section of the American Laryngological and Otological Society, January 28, 1899.

auditory canal, so much so as to prevent the position of the perforation of the membrana tympani being made out. The entire mastoid region was the seat of a red, boggy and exquisitely sensitive swelling. Temperature, 103° . No brain symptoms were present and the fundus oculi was normal.

It was obvious that an immediate operation was necessary, but its performance had to be deferred until morning, because of the inadvisability of doing it by artificial light and the danger of using ether then.

The poor child passed a night of dreadful suffering, but little relieved by anything I could do.

The following (Thursday) morning at 5:30 o'clock, with the assistance of Drs. Munroe and Bell, the patient fully under ether, I proceeded to operate.

An incision was made through the long axis of the swollen and infiltrated tissues, extending from the upper margin of the mastoid to well beyond its tip. Upon reflecting the periosteum, the bone near the apex seemed soft and vascular, and was readily penetrated by the chisel, without the use of the mallet and a considerable quantity of pus escaped. The opening was carefully enlarged by the chisel and sharp spoon in the direction of the antrum, which was also opened and more pus escaped; a considerable amount of granulation tissue was removed by the spoon until the entire cavity was clean and smooth and free communication with the middle ear was established. The cavity was then syringed with a solution of carbolic acid packed with iodoform gauze, over which the same was loosely laid, covered with absorbent cotton and held in place by a firm roller bandage.

The hemorrhage was trifling and the ether well borne. Immediately after the operation I returned to the city, and did not see the patient again until Friday evening, August 19.

The report from Dr. Munroe was that after the operation the temperature fell to the normal, she passed a comfortable day and slept well during the night, and although she took but little nourishment she vomited frequently. On Friday morning as soon as she awoke, most alarming vomiting set in and continued until Saturday afternoon before it was under control. By the time I reached her bedside, early in the evening, her condition was fast becoming alarming. She had vomited since the early morning almost incessantly, and could retain no food whatever, even a teaspoonful of milk or boullion would be instantly rejected, and when the stomach was quite empty, she made almost constant efforts at vomiting, which often came on in the most sudden and projectile manner, so characteristic of cerebral vomiting.

Small doses of calomel which Dr. Munroe had been giving at short intervals, had not the least effect in checking the vomiting.

I staid with the patient from this time on until the vomiting ceased.

Gave her grain doses of oxalate of cerium every hour, put a mustard plaster on the stomach and fed her carefully with small doses of milk, beef tea and stimulants at short intervals; which, with perfect quiet, arrested the vomiting after it had lasted nearly forty-eight hours.

During all this unpleasant experience the temperature remained about normal, there was no pain, nor other symptoms of cerebral disease.

On Sunday at 2 p. m. there was slight rise of temperature, $99\frac{2}{5}^{\circ}$. The patient was very weak and exhausted, but was cheerful, free from pain and took nourishment well.

Wound was aseptic, hardly any discharge and looked well. I now considered her out of all danger and took my departure, leaving the case in Dr. Munroe's hands, who was kind enough to send me a daily bulletin for sometime.

On the 22d temperature was $98\frac{2}{5}^{\circ}$, had a good night; 23d, morning temperature normal; evening, $99\frac{3}{10}^{\circ}$; 24th, $98\frac{2}{5}^{\circ}$ morning; 25th, evening temperature 98° ; 26th and 27th, morning temperature, $98\frac{1}{5}^{\circ}$; evening, $98\frac{4}{5}^{\circ}$.

In a letter from the doctor, September 4th, he says: "the evening temperature sometimes reaches 99° . Wound healthy—still some discharge. Patient fairly convalescent." From this time on the progress of the case was uneventful, and complete recovery ensued in about six weeks.

Case II—Otitis Media Acuta—Mastoid Extension—Operation—Convalescence Complicated by Acute Empyema of the Frontal Sinus.

D. M., aged thirty-seven, policeman, who had but recently recovered from right-sided hemiplegia, tall, thin and of a cadaveric look, was admitted to the New Amsterdam Eye and Ear Hospital, on Wednesday, September 14th. About a week before his admission he first began to have pain in the tonsillar region, soon thereafter extending to the middle ear on the right side; two days later perforation of the membrana tympani and otorrhea took place. He was treated by Dr. Dan'l Smith, his family physician, with leeches and hot applications. On his admission we found a large perforation of the anterior inferior quadrant of the membrana tympani, bulging of the posterior wall of the auditory canal and but scanty discharge of pus. There was neither swelling nor redness of the

mastoid region, but deep pressure over the bone, especially near its tip, gave rise to considerable pain. His suffering, however, was very great, and his statement to this effect borne out by his appearance.

Pulse, 100; temperature, $100^{\circ}/_{10}^{\circ}$. He was put in bed, Leiter's coil applied over the mastoid, a leech in front of tragus and the ear frequently syringed with hot water which seemed to give him some relief.

September 15th, had a good night, feels better, temperature still 100° , pulse only 72. Tenderness less, only elicited by pressure over the apex of the bone.

During the morning the house surgeon reported that he had had quite a profuse discharge from the right nostril which had a foul smell; at this time, I thought it might have come from the middle ear by way of the Eustachian tube, but the subsequent developments in the case did not bear out this view.

When I saw him again at 3 p. m., in spite of apparent amelioration of his symptoms, I decided to operate, which I did in the presence of his family physician and the hospital staff.

The patient took ether badly, several times becoming very cyanotic and his pulse growing feeble, so that the operation had to be suspended until he was recuscitated. The usual Schwartz's operation was done. The periosteum was somewhat thickened and difficult to detach from the bone; the outer plate was very hard, had to be chiseled into, but on getting into the cortex it was soft, vascular and upon reaching the antrum pus escaped with the blood. After enlarging the opening with the chisel it was surprising (considering the acute nature of the disease) what a quantity of granulation tissue there was. This was all removed by the use of Volkman's spoon; the tip was comparatively healthy, but nevertheless all of the bone which seemed to be in any degree softened was removed.

The large cavity thus formed was carefully irrigated with a warm solution of bichloride 1:5,000, the fluid escaping through the external meatus. The wound was packed with gauze and dressed in the usual way.

At 7:30 p. m. pulse 96, temperature $99\frac{1}{2}^{\circ}$. Ether caused much nausea and gastralgia.

September 16th, feels better, complains of throbbing pain in the ear and tinnitus; temperature, 99° ; pulse, 72. At 12 m. temperature rose to $99^{\circ}/_{10}^{\circ}$ and he began to have intense pain in the ear and over the right eyebrow, the wound was dressed and it and the ear syringed by the house doctor which gave him considerable relief.

In the afternoon when I saw him he still complained very much of the frontal pain, which excites his apprehension. Slight palpation over the frontal sinus is painful. During the night he says he has had a profuse purulent discharge from the nose, and during the morning on two different occasions. I now suspected that the localized head-ache might be due to inflammation of the frontal sinus and, therefore, got my colleague, Dr. Robert C. Myles, to make an examination of the nose. He found pus was discharging from the upper anterior end of the hiatus semilunaris, which flowed downward in a perpendicular direction, the position of the pus and direction of its flow indicated that it came from the infundibulum and frontal sinus. Inhalations of carbolic acid, eucalyptol and turpentine, aa. \mathfrak{z} i in aqua Oj gave him great relief from pain. In the evening his temperature rose slightly, $99^{\circ}/_{10}$. The next day, again there was a slight rise of morning temperature which continued throughout the day, reaching the maximum height of $100^4/_{10}$ at 8 p. m.

He still had intermitting head-aches of the same kind, at times very severe, but always better when there was a discharge from the nose or inhalations were used.

From September 19th to 23d there was a slight rise in temperature, the evening temperature reaching 99° and a fraction, when it became normal, but from this time on to the 30th he had a sub-normal temperature, ranging from 96° to 98° .

The wound looked well, there was never any retention of pus, drainage was good, the pain gradually became less and the discharge from the nose stopped entirely, but he was very weak and feeble. On the 30th he left the hospital, and in about three weeks thereafter had entirely recovered and went back to duty on his post as a policeman.

Both of these cases seem to me have been of interest enough to call your attention to.

The first on account of the severe and long continued vomiting, lasting for nearly forty-eight hours after the operation and becoming very serious. The question to decide, was, whether this was due alone to the effect of ether or was caused by cerebral disease.

Absence of fever helped us to exclude any inflammatory affection of the brain or its meninges, or sinus thrombosis, but it was not as decisive an aid in helping in the exclusion of an abscess, either cerebral or epi-dural. From the length of time which the ear disease had existed before the operation, there was a possibility of the existence of either of the conditions.

Sinus thrombosis could be excluded by the absence of any chill or considerable rise of temperature, which remained almost normal, or with but a slight rise throughout, no more, indeed, than could be accounted for by the trauma induced by the operation.

In view of these facts and the absence of pain, I thought it safe to wait, and to use only measures to arrest the vomiting, which was, no doubt, caused by the ether, although its long continuance made me apprehensive of some cerebral complication.

In the second case, although there was at no time after the operation very much rise in the temperature, the highest point reached being $100^{\circ}/10^{\circ}$, yet the persistent frontal head-ache suggested the possibility of the formation of an abscess.

This localized pain, however, as it turned out, was, undoubtedly due to acute empyema of the frontal sinus, as shown by the purulent discharge from the right nostril, the discharge of pus from the upper end of the hiatus semilunaris, observed by Dr. Myles, and the entire relief afforded by the treatment directed to this condition. My own experience does not enable me to say whether this is a common complication or not, but I wish to call attention to the possibility of its existence as a cause of severe frontal pain, after a mastoid operation, which might be mistaken for a more grave condition.

In conclusion, I desire to point out that there may be other reasons for the symptoms of vomiting and localized pain happening during the healing of a mastoid operation than an extension to the brain or involvement of the sinuses, although we must constantly have these in mind; and that it may sometimes be the course of prudence to act, as was done in these cases, in a conservative manner, rather than too hastily to decide on a further operative procedure.

**Ear Diseases Coexistent with Adenoids of the Naso-Pharynx—
An Analysis of 110 Cases—**WM. BRAISLIN, Brooklyn—*Phila.
Med. Journ.*, February 20, 1899.

In an analytical paper the author calls attention to the intimate anatomical relationship between the pharynx and ear. He emphasizes the well-established view of modern aurists upon the importance of removing the exciting factors when same exist. Ear disease in some degree will always be found accompanying the adenoid growth. Treatment of the aural condition should always be continued for some time after the removal of the growth.

LEDERMAN.

PNEUMATIC MASSAGE IN THE TREATMENT OF DEAFNESS AND TINNITUS.

BY GEO. A. WEBSTER, M.D., BOSTON, MASS.

Senior Aurist to St. Elizabeth's Hospital; Clinical Assistant, Massachusetts Eye and Ear
Infirmary; Instructor in Tuft's College Medical School; Instructor in Boston
Polyclinic; Member Massachusetts Medical Society, Etc.

The following cases represent an attempt to learn something of the value of pneumatic massage. They include conditions resulting from chronic suppuration of the middle ear, varying from small perforation to complete destruction of the tympanic membrane. The observations were made on cases where the suppuration had ceased and the middle ear was dry.

This is a class of cases where the prognosis as regards improvement is not as a rule very favorable, except where an artificial drum improves the hearing.

With one exception, case C, they were treated without the catheter, as we wished to ascertain the results of pneumatic massage alone. To get the best results, treatment to improve the condition and patency of the Eustachian tube would often be necessary in addition to the massage. The tests were made on out-patients and are partly dependent on their observations. They stand as recorded, though in some cases they do not altogether correspond. The massage was given through a Siegle's speculum by means of an air pump controlled by an electric motor. It was so arranged that the speed and power of the impulse could be increased or diminished; and so managed that the first stroke of the piston produced rarefaction of the air in the meatus and suction outward on the tympanum:

Case A. Right: Effect of suppuration, with tinnitus.

TEST SEPT. 10, 1897.

Watch	1	R	60	L	
Voice	1	R	30	L	
Rinné.....					512 V. S.
A. C.....		R 5		L	
B. C.....		R 20			
Weber 256 V. S..	R	<		L	

TEST NOV. 17, 1897.

Watch	1	R	60	L	
Voice	1	R	25	L	
Rinné.....					512 V. S.
A. C.....		R 10		L	
B. C.....		R 20			
Weber 256 V. S..	R	>		L	

TONE LIMITS:

Galton R 1 L
Forks R 64 L

TONE LIMITS:

Galton R Normal L
Forks R 64 L

Pneumatic Massage: Sept. 10, 14, 17, 21, 24, 28, Oct. 1, 8, 16, 26, Nov. 5, 17.

Oct. 5. Tinnitus nearly gone.

Nov. 17. Tinnitus formerly so marked that it interfered with her going to sleep. Now she rarely notices it. Says she can understand conversation better than before treatment.

Case B. Right and Left: Effect of suppuration, with destruction of membrana tympani, with tinnitus.

TEST SEPT. 15, 1897.

Watch R $\frac{2}{60}$ L $\frac{2}{60}$
Voice R $\frac{3}{30}$ L $\frac{2}{30}$
Rinné 512 V. S.
A. C. R 7 L 7
B. C. R 23 L 18
Weber 256 V. S. R = L

TEST OCT. 9, 1897.

Watch R $\frac{2}{60}$ L $\frac{2}{60}$
Voice R $\frac{5}{30}$ L $\frac{3}{30}$
Rinné 512 V. S.
A. C. R 7 L 12
B. C. R 15 L 30
Weber 256 V. S. R = L

TONE LIMITS:

Galton R 1 L 1.5
Forks R 256 L 64

TONE LIMITS:

Galton R 1 L 1.5
Forks R 64 L 64

Nov. 27. Forks 256 each ear.

Tinnitus better for a few days after each treatment, then returns same as before.

Pneumatic Massage: Sept. 15, 18, 25, 29, Oct. 9, 13, 16, 23, 28, Nov. 17, 24, 27.

Has not been treated since November, 1897, except by catheter.

TEST OCT. 18, 1898.

Watch R $\frac{2}{60}$ L $\frac{2}{60}$
Voice R $\frac{1}{20}$ L $\frac{2}{20}$
Rinné 512 V. S.
A. C. R 7 L 15
B. C. R 17 L 25
Weber 256 V. S. R = L

TONE LIMITS:

Galton R 1.5 L 2
 Forks R 256 L 256

Case C. Right: Effect of suppuration with perforation of membrana tympani. Left: Effect of suppuration with destruction of membrana tympani. Tinnitus in both.

TEST SEPT. 13, 1897.

Watch R $\frac{0}{60}$ L $\frac{0}{60}$
 Voice R $\frac{1}{30}$ L $\frac{1}{60}$
 Rinné 512 V. S.

A. C. R 20 L 10

B. C. R 25 L 22

Weber 256 V. S. R = L

TONE LIMITS:

Galton R 1 L 1
 Forks R 64 L 64

TEST NOV. 5, 1897.

Watch R $\frac{3}{60}$ L $\frac{2}{60}$
 Voice R $\frac{10}{25}$ L $\frac{5}{25}$
 Rinné 512 V. S.

A. C. R 20 L 7

B. C. R 25 L 20

Weber 256 V. S. R < L

TONE LIMITS:

Galton R 1 L 1
 Forks R 64 L 64

Pneumatic massage, both. Catheter, right. Sept. 13, 16, 20, 28, Oct. 1, 8, 12, 19, 22, 26, Nov. 1, 5.

Oct. 22. Tinnitus less.

Case D. Left: Effect of suppuration with perforation of membrana tympani; tinnitus.

TEST SEPT. 24, 1897.

Watch R L $\frac{1}{2}$
 Voice R L $\frac{60}{60}$
 Rinné 512 V. S.

A. C. R L 3

B. C. R L 13

Weber 256 V. S. R L

TONE LIMITS:

Galton R L 1
 Forks R L 64

TEST NOV. 12, 1897.

Watch R L $\frac{1}{2}$
 Voice R L $\frac{60}{60}$
 Rinné 512 V. S.

A. C. R L 15

B. C. R L 25

Weber 256 V. S. R L

TONE LIMITS:

Galton R L 1
 Forks R L 64

Pneumatic massage, Sept. 24, Oct. 1, 8, 16, 22, 29, Nov. 5, 12, 19.

Nov. 19, 1897. No tinnitus.

Nov. 4, 1898. Has had but little tinnitus in last year. Has been under treatment (Politzer air douche) most of year. This, however, had been tried before pneumatic massage and had failed to relieve tinnitus. Improvement dates from massage and has been permanent.

Case E. Right: Effect of suppuration with destruction of membrana tympani. Left: Effect of suppuration with tinnitus.

TEST OCT. 28, 1897.

Watch R $\frac{0}{60}$ L $\frac{0}{60}$
Voice R Loud voice L Loud voice
Rinné 512 V. S.

A. C. R 5 L 10
B. C. R 15 L 15
Weber 256 V. S. R = L

TONE LIMITS:

Galton R 3.5 L 2.5
Forks R 512 L 64

Pneumatic massage, Oct. 28, Nov. 1, 2, 3, 4, 5, 6, 8, 9, 11, 15, 18, 22, 26.

Nov. 26. Self and friends observe that patient can hear conversation better. Tinnitus constant for many years, now intermittent.

Case F. Right: Effect of suppuration with perforation of membrana tympani. Left: Effect of suppuration with destruction of membrana tympani.

TEST NOV. 12, 1897.

Watch R $\frac{1}{60}$ L $\frac{0}{60}$
Voice R $\frac{5}{25}$ L Medium voice
Rinné 512 V. S.

A. C. R 30 L 5
B. C. R 35 L 12
Weber 256 V. S. R = L

TONE LIMITS:

Galton R 2 L 4.5
Forks R 40 L 512

Pneumatic massage, Nov. 12, 16, 19, 22, 26.

TEST NOV. 30, 1897.

Watch R Contact L Contact
Voice R Low voice L Loud whisper
Rinné 512 V. S.

A. C. R 7 L 25
B. C. R 15 L 15
Weber 256 V. S. R = L

TONE LIMITS:

Galton R 2 L 2
Forks R 256 L 40

SUMMARY.—HEARING.

Case A. Gain very slight.

Case B. Slight gain at first, followed by slight loss. The loss came after increase in force of massage over that usually given.

Case C. Gain right 9 feet, left 5 feet. In this case the right was treated by catheter also.

Case D. Whisper heard after, not before treatment.

Case E. Watch heard in each ear after, not before treatment. Right increased from loud to low voice, left from loud voice to loud whisper.

Case F. Gain right 10 feet. Left, medium voice to loud whisper.

TINNITUS

Case A. Relief marked.

Case B. Relief temporary only after each treatment.

Case C. Tinnitus less.

Case D. Relief permanent.

Case E. Tinnitus less.

The cases showing the greatest gain in hearing were cases where suppuration had recently ceased. The case D showing relief of tinnitus permanently, was not a recent case.

CONCLUSION.

In the class of cases above mentioned, pneumatic massage may be of considerable value in addition to other means of treatment. I was unable to realize any greater benefit from very rapid vibrations than from slow. I therefore see no advantage to the patient in a motor, but think a Siegle speculum with a hand bulb, or Delstanche's masseur, would do equally well. Though in a series of cases a motor is more convenient for the operator. Moreover, the rapid vibrations were attended with some noise which was at times disagreeable to the patient.

CORRESPONDENCE.

February 10, 1899.

Editors THE LARYNGOSCOPE:

DEAR SIRS—I have only to-day had the good fortune to read your issue of June, 1898, and I feel that an apology is due from me in venturing to offer a criticism of matter which appeared in a number now eight months old. The matter I refer to is contained in the article "What is the Best Operation for Adenoids," which occupies your editorial pages, and it is this circumstance adding so much weight to the opinions therein expressed which impels me to trouble you with so tardy a comment. I trust you will take my appreciation of the importance of your article as my apology. As one would expect in so prominent a journal, your editorial is a review of general opinion, and not an expression of personal bias. At the same time I would venture to say that the criticism of Gottstein's curette shows a want of appreciation of the proper use of that instrument. Speaking of "tough" growths you say, "it is not reasonable to expect that an instrument like Gottstein's forceps (which is evidently a printer's error for 'curette') which scrapes rather than cuts the growth, will thoroughly remove it." It is, of course, clear that you do not personally make use of this instrument, but I think I may also add that you have misinterpreted the experience of those who do so. Gottstein's curette is essentially a cutting instrument, and when the sharp edge is used in a proper condition of repair, the latter will, without difficulty, cut through the toughest and smallest "adenoids" without riding over them or "scraping over the surface," to use your own words. The proper method of using the instrument is not one which is learned in a day, and indeed, I believe, that the principal surgical error for which Gottstein's method is responsible is the deceptive appearance of simplicity, in practiced hands, which has led so many inexperienced operators to undertake its use without detailed instruction. It would be wholly out of place in me to describe the method, which is fully detailed elsewhere by competent authorities, but I would venture to suggest a close observation of the working of this instrument in the removal of post-nasal growths in a case of cleft palate. You will then see that with a firm and somewhat

rapid sweep, following the contours of the space to be cleared, the growths are cleanly severed at their attachment, and subsequent examination under the microscope will convince you that the fibrous structures are contained in the specimen and not left behind denuded of their lymphoid covering. It will also be clear to you how well contrived is this instrument to permit of the removal of masses attached close to the root of the vomer and of small out-lying growths situated, if not in Rosenmüller's fossa, at all events very close to the Eustachian eminences.

I am quite at one with you in thinking that Gottstein's instrument is singularly ill-adapted for "curetting out the narrow recesses on the wall of the space *anterior* to the Eustachian prominences." I am not so temerous as to express any opinion as to the best method of clearing that part of the post-nasal space as I have no experience in the matter. I shall, I think, not be singular in reporting that I have not met with a case requiring that operation after examining several thousand cases of adenoids during the last few years.

In venturing to write to you I have no intention of opening up a discussion on this vexed question as to the best method of operating for adenoids. The operation is one of which all hospital surgeons have a large experience and every opportunity of forming a personal opinion, and it is, I think, for this reason the less desirable that young surgeons should commence their career with a prejudice. I feel that possibly you have not weighed the influence which words, coming from so eminent a source, may have upon the rising generation of rhinologists, and I therefore venture to express a hope that your editorial columns will not permanently pass judgment on Gottstein's method of operating without a somewhat more extended examination of witnesses.

I am, sirs, yours very truly,

ERNEST WAGGETT.

45 Upper Brook Street, London, W.

SOCIETY PROCEEDINGS.

NEW YORK ACADEMY OF MEDICINE.

SECTION ON LARYNGOLOGY AND RHINOLOGY.

Stated Meeting, February 22, 1899.

Robert C. Myles, M.D., Chairman.

Fibroma of the Naso-Pharynx.

Dr. Francis J. Quinlan presented a tumor of the naso-pharynx which he had removed through the mouth by means of a cold wire snare. He had succeeded in doing this without exciting bleeding, as he had made use of cocain and supra-renal extract. Examination of the specimen had shown it to be a fibroma.

The growth was present for eight years, and during this time the patient was seen by many physicians, as the large size of the neoplasm interfered with respiration as well as deglutition. It was suspended from the pharyngeal vault, filling up the entire rhinopharynx, the iso-pharynx and resting upon the epiglottis and arytenoids. Marked suppurative attacks supervened and unconsciousness was noticed by the parents of the girl. Since its removal marked improvement has taken place, the patient's appetite is better and she now can rest in the recumbent position. She has gained twelve pounds in two weeks.

A Case of Primary Pharyngeal and Laryngeal Tuberculosis Apparently Cured—Remarks on Kalagna, a New Remedy for Tuberculosis.

Dr. Joseph W. Gleitsmann reported this case, and presented the patient for examination.

Regarding the new remedy, kalagna, Dr. Gleitsmann said that it is being furnished by the Belgian Consul in South America, and heretofore the supply of the remedy in this country had been exceedingly limited. This, however, would soon be rectified. The remedy had a taste resembling that of garlic. In Belgium it had been fed in large quantities to a dog without any deleterious effects. The preparation was easily taken, and did not disturb the digestion. Kalagna has been supplied to Dr. Stubbett, of Liberty; Dr. Trudeau, of Savannah; Dr. Henry P. Loomis, of New York, and

Dr. Mechtold, of Staten Island. Last summer Dr. E. L. Trudeau, of the Adirondack Sanitarium, had three patients on this treatment, two being in the beginning, one quite advanced in the disease. His conclusion was that the improvement in the two patients appeared to be accelerated by the remedy, but no more so than he had observed from climatic and other influences. Dr. Stubbert had merely reported that he had treated twenty-five cases with this remedy, with satisfactory results. Dr. Loomis had reported that he had tried it on three cases, and had been pleased with its action. Dr. Mechtold had tried it in three cases. In one of these the patient, a Spaniard, who had been treated four years previously for tuberculosis with large doses of guaiacol and of Koch's tuberculin, and who had been discharged "cured," had returned last summer with a renewal of the symptoms of pulmonary disease. He had then been put on the kalagna, with the result that the symptoms had disappeared, and he had gained in weight. In a second case, that of a German, fifty-four years of age, a laborer in a dusty factory, the symptoms of pulmonary tuberculosis had first appeared last spring. This man had been taking the kalagna since last July, with the result that he had regained his flesh and strength, had been able to resume his occupation and now felt well. No other remedy had been given.

Dr. Gleitsmann then reported the following apparent cure of primary pharyngeal and laryngeal tuberculosis, and presented the patient, a lady of thirty years. He said that she had first come under his treatment during the summer of 1896. At that time the whole free border of the epiglottis had been one ragged ulcer. He had placed her in hospital, and on November 5th had excised the whole border of the epiglottis, and one arytenoid without causing any reaction. Altogether twenty-one pieces of tubercular tissue had been excised. Early in January, 1898, an ulceration appeared on the right side of the base of the tongue, and owing to the tendency to bleeding, lactic acid had been injected twice. The ulcer had completely healed by the latter part of February. On April 12th there had been a large ulcer at the middle of the base of the tongue, and this had proved to be the most obstinate of all to treatment. He had made five submucous injections of lactic acid and had done six curettings. During all this time the dysphagia had been so extreme that she could only take food after insufflation of orthoform. Since December there had been no ulceration or infiltration. At present the patient had her normal weight, looked well, and was apparently cured.

Dr. W. F. Chappell reported, through the Secretary, that in his throat service at the Loomis Sanitarium there had been no success whatever with kalagna, although it had been used quite largely, and that the treatment with it would, therefore, be discontinued.

Dr. Emil Mayer said that he had seen Dr. Gleitsmann's patient last spring at the meeting of the American Laryngological Association, and recalled the undoubted tuberculous manifestations present at that time. The manifest improvement shown here is very encouraging and warrants persistence in operative measures for tuberculosis of the upper air passages.

Dr. Wendell C. Phillips remarked that no mention had been made in the report regarding the bacteriological examinations of the larynx and pharynx.

Dr. Gleitsmann replied that he had unintentionally omitted to mention that a number of bacteriological examinations had been made, and tubercle bacilli found, and that the tissue which had been excised had also been examined, and had been proved to be tubercular tissue. The reports that he had read had referred almost exclusively to general pulmonary tuberculosis, and personally he had not found kalagna to be of value in pharyngeal tuberculosis. It was still used for pulmonary tuberculosis, he understood, in the Loomis Sanitarium.

Remarks on the Etiology of Nasal Polypi.

Dr. Jonathan Wright read this paper. He said that two years ago a girl of sixteen had come to his clinic with a history of left-sided nasal obstruction. Through the right nasal fossa a large mass could be seen, and the left nostril was blocked with polypi of moderate size. A large polyp extended down into the nasopharynx. Repeated attempts at removal of the large tumor had failed, but by evacuating the fluid and so reducing its size it had finally been possible to snare it off. On removal the tumor had been found to be lobulated. It had sprung from the middle of the convex surface of the inferior turbinate body, about one centimeter from its posterior border. At intervals of from two to four weeks for nearly a year polypi had formed near the attachment of the large tumor, and these had been promptly removed and the surface cauterized. It was now more than six months since there had been a recurrence.

It was exceedingly unusual, the speaker said, to find a large, pedunculated edematous polypus springing from this part, and it was also uncommon to observe at this age such rapid recurrence.

The tumor had probably begun to grow shortly after the age of puberty. In the back of the nose there was usually more fibrous tissue in the polypi. Most of the cysts originated from dilatation of the racemose glands, whose ducts had become occluded. In the present case there were very large cavities in the fresh polypus. Not only had the original nasal tumor been made up of these cavities, but the same was true of the recurring buds. Any process which disturbed the bony canals and their contents might be supposed to disturb the mucosa covering the bone. Dr. Woakes, of London, had stated that the bone lesion in the middle turbinate was the primary one in the formation of nasal polypi. Bone changes, by obstructing the blood supply, were supposed to diminish the blood supply and cause atrophic rhinitis. While edema of the glottis was not unknown in cardiac and renal disease, he had never heard that the nasal mucosa underwent such change in these diseases. There could be no doubt that the changes produced by inflammation had much to do with the growth of nasal polypi, but this did not account for all of the etiology. In the majority of cases of hay fever nasal polypi would be found to exist. Usually the obstruction of the nose produced by the polypi did not begin until the hay fever had existed for several seasons. He now believed that the two phenomena were dependent upon a common cause situated in the vaso-motor nerves. A part of the process of inflammation was a spasm, followed by a dilatation of those vessels having muscular coats. There was much reason for believing that hay fever was largely the result of this vaso-motor storm, with the subsequent effusion of serum. The most vascular region of the nose was the inferior turbinate body, and it was in this region especially that polypi occurred. In brief, then, it might be said, that edematous infiltration of the nasal mucosa, either sessile, or in the form of polypi, might result from: (1) Mechanical obstruction to the venous return by the products of inflammation in the mucus or underlying bone, or (2) vaso-motor phenomena accompanying chronic inflammation, or (3) from vaso-motor phenomena present in stenosis, and giving rise to hay fever and bronchial asthma. In the case reported by him, the strict localization to one spot, the rapidity of the recurrence and the nature of the recurrent buds seemed to be best explained by the supposition that there had been in this case a sudden vaso-motor disturbance, leading to the formation of serum.

Dr. H. L. Swain, of New Haven, said that he wished to contribute a mite out of his own individual experience, thus adding to

what had been stated in the paper, but presenting nothing new. Not infrequently cases of nasal polypi were not cured, and probably because of the imperfect knowledge of the pathology of this condition. He had endeavored to show, on a previous occasion, that there was a certain association between the polyp and the membrane from which it grew, a dense fibrous tissue producing a firmer polyp than a more delicate one. A polyp was not a tumor in the sense that it was the growth of any one constituent of the membrane. It was identical in the middle turbinate region with the edematous hypertrophies. A polypus was nothing more than an elongated and dependent edematous hypertrophy, and this edematous hypertrophy differed from the simple only in the fact that in its substance between the fibers an edematous material formed, which stretched the tissue, and by forcing the fiber apart gave rise to the soft gelatinous structure. There must be first an edematous soaking of the tissue for a polyp to occur. The reader of the paper had dwelt upon the theory that the bony change might precede and cause the polyp formation, but personally he could not conceive how this could occur. Also cases existed where a polyp grew from mucous membrane having healthy tone.

Excessive irritability of the nerve fibers of different neurotic individuals led to different expressions—hay fever, neuralgia, nervous dyspepsia, etc. All neurotic subjects were victims of vasomotor explosions. It was possible that the neurasthenic habit might in some way affect the formation of the blood vessels throughout the whole body—for example, that all the veins might be abnormally thin. It was only necessary to suppose that the venous trunks in the nose had less muscular fiber to have an abundant explanation of why the mucosa of one person became waterlogged, and did not in another. In neurasthenic individuals the hypertrophic tissue in the middle turbinate was often moist and edematous. The theory of the production of atrophy by bone change assumed that there must be some obstruction to the circulation, causing a lack of nutrition, and, therefore, atrophy. Another theory seemed to assume that this same obstruction would produce an opposite effect in the middle turbinate, which does not seem altogether right.

It might be asked why these cases were ever cured if polyp formation were always dependent upon an inherent change in the tissue. The answer was to be found in the fact, that the inherent change in the tissues was in some cases local, the result of inflammation and this caused the polyp formation. In the inveterate

cases the inherent defects, being of constitutional origin, could not be cured by either local or constitutional treatment. Such cases also, ultimately, had bone lesions as the result of prolonged disease of the mucous membrane. He thought it was possible that inveterate cases might, in time, be benefited by some form of organo-therapy—quite possibly by the internal administration of the supra-renal gland.

Dr. J. E. Newcomb said that it was not difficult to see how the polyp formation continued when once it had started. It was known that the vaso-motor system was not fully developed until the age of puberty—a fact which corresponded fairly well with clinical experience. He had seen one case in which there had been a removal of a polypus in a child of eight years, and cases had been reported occurring in children only a few weeks old. Lennox Browne had claimed that there was a polypoid diathesis, and had endeavored to support the view by citing cases in which there were polypi not only in the nose, but also in the bladder and other parts of the body. The vaso-motor theory of the formation of polypi was interesting, but it must be remembered that polypi were often observed in persons in whom we would not expect to find vaso-motor storms.

Dr. W. K. Simpson thought the vaso-motor theory was supported in that type of nasal polypi in which there was a tumor of the inferior or middle turbinate bone which, on being opened, exhibited a mere shell of bone, all honeycombed and filled with polypi. Such a condition could not arise, it seemed to him, from the mucous membrane itself.

Postponed Discussion on Dr. Freudenthal's Paper on "The Treatment of Dysphagia and Cough, Especially in Tuberculosis."

Dr. Emil Mayer said that he had found that certain patients complained very bitterly of tinnitus aurium as a result of the administration of heroin. It was also well to bear in mind that as it was one of the preparations of opium it should be carefully watched. He was convinced that it was a very valuable addition to the materia medica. Regarding the use of orthoform, he would say that it did not seem to him at all necessary to use it in emulsion; his patients had borne it perfectly well in the form of powder.

Dr. Jonathan Wright said that he had been much pleased with the emulsion of orthoform, and he preferred it to any powder because powders were apt to increase the cough in these patients. He had also tried heroin in a most obstinate case of reflex cough.

The remedy had acted well for about a week, in doses of one-fifth of a grain, three or four times a day, and then it had failed just as had the other sedatives.

Dr. Simpson said that he had given heroin in powder, but in this form it had adhered to the paper; hence he believed it would be better to administer it in compressed tablets.

Dr. Freudenthal closed the discussion. He said that although he had given heroin quite extensively, he had never observed tinnitus aurium in connection with its administration. He had advised the use of the emulsion of orthoform, not because the powder could not be tolerated, but because the emulsion prolonged the application of the remedy to the surface. He was sorry that nothing had been said regarding his remarks on photo-therapy, for there was some good in it, even though as yet the nature of its action was not understood.

SIXTH INTERNATIONAL OTOLOGICAL CONGRESS, 1899.

This Congress is to be held in London from August 8th to 12th, under the Presidency of Dr. Urban Pritchard.

The meeting will be held at the Examination Hall of the Royal College of Physicians of London, and Royal College of Surgeons of England, and the following details have been arranged: On Monday evening, August 7th, a preliminary reception will be held by the President elect. On August 8th, 9th, 10th, 11th, the Congress will be in session, and will be followed on Saturday, August 12th, by an excursion for members and their lady friends.

The official languages are English, French, German and Italian.

The subscription, to include a copy of the transactions, is fixed at £1, to be paid to the Treasurer, Mr. A. E. Cumberbatch, 80 Portland Place, London, W., before the opening of the Congress.

The subject chosen for special discussion is "Indications for opening the Mastoid in Chronic Suppurative Otitis Media," which will be introduced by Prof. W. MacEwen, of Glasgow; Dr. H. Knapp, of New York; Dr. Luc, of Paris, and Prof. Politzer, of Vienna.

A museum of specimens and instruments relating to otology, shown by members, will be held during the meeting. Communications regarding the museum should be addressed to Mr. A. H. Cheate, 117 Harley Street, London, W.

Intending members of the Congress are requested to send in their names to the Hon. Secretary General as soon as possible, and in any case *not later than May 1st*. Titles of communications, together with a short abstract of the same, to be sent to the Hon. Secretary General by the same date. According to the regulations of the Congress, no papers shall exceed fifteen minutes in reading; therefore all long communications should be read in abstract.

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ABSTRACTS AND BIBLIOGRAPHY.

I. NOSE.

Naso-Pharyngeal Polyp of Unusual Size and Form—WEIL—

Wiener Med. Wochenschr., January 26, 1899.

At a meeting of the Vienna Laryngological Society Dr. Weil exhibited a polyp which was attached all along the posterior edge of the vomer. Two hemispherical processes filled the naso-pharynx and obstructed the choanæ. A large branched process filled the right nostril as far as its anterior opening; while a pear-shaped portion, whose lower extremity could only be seen by strongly depressing the tongue, covered the whole posterior pharyngeal wall. Weil succeeded in removing the whole polyp in one piece. Its longest diameter was 12 c. m. and its weight 45 grams. VITTUM.

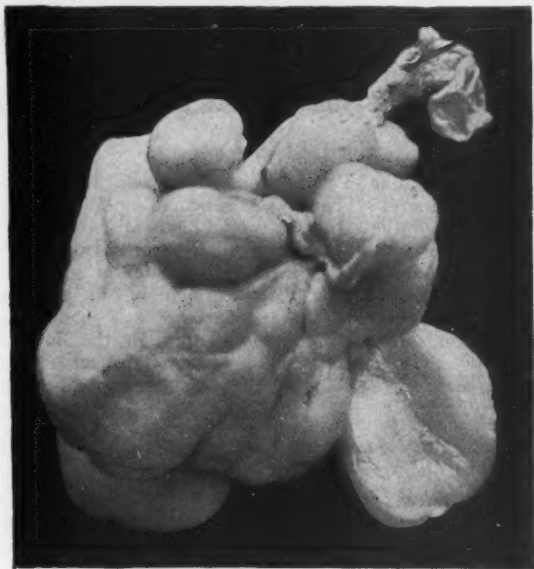
Naso-Pharyngeal Polypus of Enormous Size—MAX THORNER,

Cincinnati—*Med. News*, January 21, 1899.

A white man, thirty years old, had for eight years been troubled with inability to breathe through his nose, fulness in the head and deafness and continuous roaring noises in the ears. He had the characteristic expression of a mouth-breather. Hearing was very much diminished, and the voice had the characteristic nasal twang.

A large polypoid mass of grayish color and glistening surface about the size of a pigeon's egg could be seen protruding below the right side of the soft palate, which was immovable during phonation. Upon lifting the palate with a palate hook, enormous white masses of irregular size were seen to fill the entire post-nasal space. The site of origin of these masses was apparently somewhere on the right side of the pharynx. The left nasal fossa was free, but the right fossa was filled posteriorly with the same polypoid masses.

A cold-wire snare was introduced behind the soft palate, and pushed up as far as possible over the polypoid masses. After some



Exact size of naso-pharyngeal polypus removed from the patient.

difficulty an enormous mass of polypoid tissue was extracted, comprising the entire growth, which represented one large polypus, and which was formed of many large and small lobules. Some of these lobules were of the size of a small hen's egg. The tumor was attached by a slender pedicle of the diameter of a thin lead-pencil to the right lateral wall of the pharynx just in front of the orifice of the Eustachian tube, and after the operation the bleeding point of its insertion could readily be seen with the aid of a rhinoscopic mirror.

The growth was a so-called mucous polypus, a true fibroma edematosum, but not a naso-pharyngeal fibroma. This polypus undoubtedly originated in the posterior portion of the right nasal fossa near the choana, and by reason of its location and weight descended into the post-nasal space, where the conditions for its unusual development were very favorable. The hemorrhage following the operation was insignificant. The largest diameter of this tumor was $2\frac{3}{4}$ inches, its greatest thickness $1\frac{3}{4}$ inches, and its weight 1 ounce 5 drams. No recurrence had taken place eight months after the operation. A. A.

Papilloma of the Nasal Septum—B. DOUGLAS—*N. Y. Med. Jour.*, January 7, 1899.

A clinical history and a description of a case of papilloma of the nose, illustrated by four excellent photo-micrographic views of the specimen. SCHEPPEGRELL.

Sarcoma of the Nasal Septum—J. P. CLARK—*N. Y. Med. Jour.*, January 7, 1899.

A man of thirty-five years had had an obstruction of the left nostril for three months, due to a bluish-gray mass which was removed by the cold wire snare. There were repeated operations, but the patient succumbed to the extensive spread of the disease.

The second case was that of a woman of forty-two years, with family history of cancer. A dark reddish-gray tumor filled the anterior portion of the left nostril. A histologic examination showed it to be a myxo-sarcoma. Transverse incision was made over the bridge of the nose, the nasal bone sawed through, the nose turned down over the mouth and the whole diseased process extirpated. There was no recurrence. The article gives an excellent résumé of the literature of this subject. SCHEPPEGRELL.

Epithelioma of the Nose Treated with Caustic—I. N. BLOOM—*Int. Jour. Surg.*, Vol. xii, No. 1, January, 1899.

Four weeks after the appearance of a pimple on the nose of a lady, aged fifty-three, there was a typical development of epithelioma, involving the base of the nostril, the inside of the ala, and the cartilaginous septum of the left side. There was no history or evidence of tuberculosis, and syphilis was excluded by specific treatment. The growth was curetted completely, and caustic potash applied freely and thoroughly. Patient made a good recovery. Three or four weeks after operation there was a minute spot, which was cauterized; patient is now in good condition. Diagnosis was confirmed by the microscope. EATON.

A Case of Epithelioma of the Left Ala of the Nose—KRAKHT—*Vratch, Warsaw*, No. 46, 1898.

After thorough curetting, the diseased area was cauterized, which was followed by rapid cicatrization without recurrence. SCHEPPEGRELL.

Headaches, with Especial Reference to Nasal and Ocular Head-aches—A. D. MCCONACHIE, Baltimore—*Mary. Med. Journ.*, March 4, 1899.

There is no symptom of disease or functional disease which is so general as this affection.

All causes must be looked into. Each organ must be examined, and general causes eliminated, before local disease can be blamed.

Headaches of nasal origin usually begin intermittently; an acute coryza exaggerates the symptom. In a dry atmosphere the attacks are not frequent. The pain may be referred to the brow, temples, eyes or scalp. The general health of the patient suffers; inability to sleep is often present, mental vigor and memory become impaired and melancholia may follow.

Catarrh of the neighboring parts may complicate the nasal disease. Mouth breathing causes a coated tongue, and this suggests dyspepsia to the careless observer.

Inspection of the nasal cavity assists the examiner in arriving at a proper diagnosis. Cocain is a valuable adjuvant in clearing up the cause of the headache in nasal disease.

If any disease of the nose or accessory cavities is found, same must be treated without delay. The eye not infrequently is the exciting factor in chronic forms of headache, and should not be overlooked in trying to find the cause in such conditions.

LEDERMAN.

Connection between Ocular and Nasal Diseases—MÜLLER—*Münchener Med. Wochenschr.*, January 17, 1899.

At a meeting of the Medical Society of Magdeburg Dr. Müller read a paper on the above subject. The intimate anatomical relations existing between the eye and the nose are shown. Disturbances are divided into those inflammatory processes which are conveyed directly from the nose into the orbit and those secondary inflammations which result from empyemas of the accessory cavities. In addition to these two forms are the reflex disturbances which are very numerous.

VITTUM.

On the Connection between Nasal and Ocular Disease—ERNST WINCKLER—*Sammlung zwangloser Abhandlungen aus dem Gebiete der Nasen- Ohren- Mund- und Hals-Krankheiten*, III Band, Heft 1, 1898.

This valuable treatise should be read in the original by all who are especially interested in the subject. It does not lend itself well to abstracting and anything more than the merest glimpse at the various divisions of the work is impossible here. The author begins with the ordinary intra-nasal diseases, such as hypertrophy, polypus, etc., and endeavors to show their manner of influencing ocular conditions. His conclusion is that the method of influence is threefold: through the circulation of blood and lymph, through continuity of the connective tissue, and through nervous connections.

The anastomoses between the venous systems of the nose and orbit are carefully described, as are also the connections between the lymphatic channels of the two cavities. With similar care the orbital connective tissue is traced into the nose and pharynx. Lastly, the close connection between the nerves of the nose and eye, as regards both sympathetic and sensitive fibers, is shown at length.

In the case of nasal swellings with ocular complications the author says that galvano-cautery should be entirely avoided and advises that all superfluous tissues be removed by some cutting operation. This to avoid post-operative hyperemia and swelling.

The indications for operation are summed up as follows: 1. Where the nasal opening of the lachrymal duct cannot be reached by a probe either on account of a swollen condition of the lower turbinal or because the latter is pushed against the nasal wall by a septal growth. 2. Where ophthalmoscopic examination reveals a hyperemia that can only be explained by local circulatory disturbances. 3. Where sensory disturbances can be referred to the nasal stenosis.

The ocular diseases resulting from empyema of the various accessory cavities are next taken up and dealt with in the same exhaustive manner that characterizes the whole work. The symptoms and conditions caused by empyema of the various sinuses are too numerous even to be mentioned here. A careful survey of the regional anatomy of the different cavities is given. This is followed by a thorough discussion of the abnormalities and variations. This part of the work is illustrated by numerous cuts taken from specimens. The closing pages are devoted to a description of certain operations which have been devised to meet the requirements of the different cases.

Winckler regards the ethmoid with its system of cells as, so to speak, the center of distribution for most of the purulent infections, inasmuch as by direct communication an infection may be carried from this point either upward into the frontal sinus, downward into the maxillary sinus, or backward into the sphenoidal sinus.

VITTUM.

Rhinoplasty by an Adaptation of the Flap-Splitting Principle—

G. C. COTTAM—*Western Med. Rev.*, Vol. iv, No. 1, Jan. 16, 1899.

The author treats only of nasal lesions in which the nasal bones and a small part of the upper lateral cartilages are left intact, and applied to the principle as follows: A lad of sixteen suffered total demolition of the nose almost down to the nasal bones from the bite of a horse. After cicatrization, realizing the futility of employing flaps taken from the cheeks or forehead to form a natural appearing nose, the following procedure was planned and executed: "A transverse incision was made about five millimeters from and parallel with the free border of the portion remaining, extending 3.5 centimeters beyond the maxillary junction on each side. This incision penetrated into the nasal vault and was joined by another at right angles, which severed the part below the first incision from its septal attachment. There was thus fashioned a long, narrow strip

composed of skin and cartilage shaped like a letter U, confined at the ends but free in the middle. This was drawn down and anchored to a new columna taken from the upper lip, a single stitch sufficing. The quadrangular gap thus left above was then filled by sliding flaps from the cheeks. Interrupted open sutures of fine silk were used, and an impervious coating of aristol-collodion applied. Primary union resulted throughout, with the exception of one small spot in the median line. * * * This was promptly remedied by a graft from one arm." [The photograph of this case from unretouched negative shows a remarkably natural looking nose, particularly as to columna and alæ.—Ed.] The author believes that the subcuticular suture of Halstead would be valuable in such cases. The fundamental principle emphasized by the author is the transposition of the margins of the upper lateral cartilages to the location of the lower lateral cartilages so as to form a framework of sufficient rigidity to maintain the contour of the new alæ and so preserve the patulousness of the nostrils.

EATON.

Seeing Through the Nose—DOULIOT—*Revue Int. de Rhinologie, etc.*, December, 1898.

The author reports a case of a man who learned to see through his nasal cavities after the successive loss of both eyes. The right eye had been lost in childhood; the other eye, as well as the nose, had been lost in a fall upon a stake. A year later he perceived that he was able to distinguish through the nasal aperture the light of day, and also brilliant objects placed beneath it. It is considered probable that the retina had been spared and that there remained an opening of communication between the nasal fossæ and the orbital cavity.

SCHEPPEGRELL.

A New Communication on the Application of the Roentgen Rays in Rhinology and Laryngology—MAX SCHEIER—*Archiv. Int. de Laryngologie*, September 10, 1898.

The article refers to the application of the X-rays in the examination of the frontal sinus, in the study of the physiology of the voice and in the physiology of deglutition. The author believes it to be a useful adjunct in the examination of the frontal sinus, and that it opens up a new field in the study of the physiology of speech and deglutition.

SCHEPPEGRELL.

A Contribution to the Study of Ozena—C. B. OQUENDO—*Revue Hebdomadaire de Laryngologie, etc.*, September 17, 1898.

The author believes the bacillus of Löwenberg to be the primary cause. He describes the various methods of treatment and gives preference to cupric electrolysis. He has no faith in serum therapy.

SCHEPPEGRELL.

Foreign Bodies in the Nose and Ear—EMANUEL FINK—*Klinische Vorträge aus dem Gebiete der Otologie, etc.*, II Band, 8 Heft.

A résumé of the ordinary knowledge of the subject, together with the ordinary treatment. As a curiosity may be mentioned a case where Tröltzsch removed a number of small pictures of the Virgin Mary from a patient's ear. The explanation offered was that they had been placed there by a hospital companion as a "sure preventive of deafness."

VITTUM.

Some Remarks and Facts not found in Text Books—W. P.

PORCHER—*N. Y. Med. Journal*, January 21, 1899.

The article refers to nasal obstruction and other conditions which form an every-day experience among specialists, the existence of which is frequently not recognized by the patients or by their physicians.

SCHEPPEGRELL.

II. MOUTH AND NASO-PHARYNX.

On Tonsillar Calculi—W. J. AITCHISON ROBERTSON—*British Med. Jour.*, Jan. 7, 1899.

The author records a case of tonsillar calculus in a patient aged fifty, a healthy man, he had had previous attacks of tonsillitis till three years ago, when a glandular abscess formed on the right side of the neck, which was opened and drained, since then has had no more attacks of tonsillitis. Six months ago felt fullness on right side of throat, he woke one night choking and coughed up a stone somewhat oval in shape, $1\frac{3}{4}$ inches in length and $1\frac{1}{2}$ inches in breadth, pale yellow in color and surface presented worm-eaten appearance, it weighs almost one ounce. Where calculi occur patients have generally been subject to repeated attacks of suppurative tonsillitis. The smaller concretions are probably due to the dried up non-extruded carious matter in the enlarged follicle of the tonsils, round which inorganic salts are deposited. The large calculi result probably from the retention of pus in the interior of the tonsil, the abscess has imperfectly discharged itself and the residual matter has undergone caseation and calcification. Analysis showed this calculus to be composed for the greater part of phosphate of lime and magnesia along with a small amount of carbonate.

FOX-CROFT.

Syphilitic Sore Throat—J. S. MOREMAN—*Charlotte Med. Jour.*, January, 1899.

It has been estimated that one-third of the civilized world has either inherited or acquired syphilis. While this evidence is hardly believable, the proportion is much greater than most physicians suppose.

Next to the genito-urinary organs, the tonsil is the most frequent location of chancre. In the secondary stage, even before the

characteristic spots have made their appearance, severe pain will be experienced in the pharynx, the origin of which is sometimes difficult to locate. A small ulcer will cause the whole pharynx and adjacent parts to be very painful. In this stage, as well as in the tertiary, the most reliance is in constitutional treatment, although local applications should not be neglected. SCHEPPEGRELL.

Chronic Rhino-Pharyngitis—A. MALHERLEE—*Revue Hebdomadaire de Laryngologie, etc.*, October 1, 1898.

Chronic rhino-pharyngitis is considered as distinct from rhinitis, and treatment by curetting is recommended. The author maintains that in the majority of cases the symptoms are due to hypertrophy of the mucous membrane on the site of the pharyngeal tonsil. In these cases, when involution is taking place, the tubular glands atrophy, the lymphoid masses proliferate and become hypertrophied, the whole forming a hard cushion with crypts and fissures, emitting a thick viscid secretion. Local applications are ineffective. The curetting, which should be done under bromide of ethyl, must be more vigorously applied than in children, because the masses are more resistant. SCHEPPEGRELL.

The Uvula in its Relations to Various Abnormal Conditions—G.

B. HOPE—*N. Y. Med. Jour.*, December 31, 1898.

A résumé of the various pathologic conditions which give rise to local or reflex disturbances. SCHEPPEGRELL.

On the Causes of Cleft Palate—JOHANN FEIN—*Wiener Med. Wochenschr.*, Jan. 26, 1899.

In an elaborate paper on this subject the author endeavors to show that adenoid vegetations play a very important part in keeping asunder the two approaching folds which should unite to form the palatine arch. He has examined a large number of specimens bearing on this subject and has carefully scrutinized all the cases of cleft palate to which he could gain access. As a result of his researches he says that in almost every case there are either well marked pharyngeal tonsils present, or, in the case of adults, unmistakable evidence of their having been present earlier in life.

Testimony is adduced showing that the adenoid tissue may be well developed as early as the sixteenth week of fetal life.

This to show that the mass may develop early enough to interpose an obstacle to the union of the two halves of the palate. It is further pointed out that in the fetus the various oral structures lie closely packed together and that practically there is no cavity as is the case after birth. This fact would make it much more probable that an adenoid mass might do the mischief.

At last, however, the author is compelled to say that the final and indisputable evidence of the correctness of his views can only be given by some observer who shall obtain an early fetus exhibiting an enlarged adenoid projecting between the two halves of the palate. VITTUM.

Polypus of the Uvula—E. H. GRIFFEN—*N. Y. Med. Journ.*, January 28, 1899.

While a man of forty years was being examined for follicular amygdalitis, a polypus on the uvula almost reaching the epiglottis was seen, which had, however, failed to produce irritation.

SCHEPPEGRELL.

Adenoid Vegetations and their Relation to Affections of the Ear—LUCAS—*Revue Hebdomadaire de Laryngologie, Etc.*, February, 1899.

A review of the well-known influence of adenoid vegetations in the etiology of diseases of the ear.

SCHEPPEGRELL.

The Proper Time for Operating on Adenoids—MAX HAGEDORN—*Zeitschr. für Praktische Aerzte*, Jan. 15, 1899.

This is an able paper in which the author describes some of the symptoms which follow adenoid hypertrophy and explains their mechanism. Particularly the nasal obstruction which is so often present when it cannot possibly be purely mechanical. In this case the choanæ may be obstructed at the upper part but an opening exists below. This passage, however, is not free, for often times septal spurs and ridges exist, which, together with the swollen lower turbinals and particularly their posterior portions tend to narrow it down. Furthermore, this is just the region where the tenacious mucus is most apt to accumulate and offer further obstruction to the passage of air.

In regard to the time for operating, Hagedorn says it is as follows:

1. If nasal respiration is obstructed.
2. If frequent attacks of angina appear.
3. If the hearing is disturbed.
4. If there are present nervous symptoms such as cough, enuresis nocturna, headache or aprosexia.

The author has had to operate twice in nursing infants where the obstruction was so great that life itself was threatened, because the children were utterly unable to nurse and breathe at the same time.

VITUM.

Adenoidian Asthma—LEPOUTRE—*Thèse de Lille*, 1898.

Adenoid vegetations produce asthma as a reflex disturbance, the origin of the reflex being the nasal obstruction which causes insufficiency of hematosis, compels the patient to make more forced and frequent respiratory efforts and precipitates a nervous paroxysm. The prognosis is good.

SCHEPPEGRELL.

III. ACCESSORY SINUSES.

Empyema of the Accessory Cavities—STOERK—*Wiener Med. Wochenschr.*, January 26, 1899.

At a meeting of the Vienna Laryngological Society Stoerk spoke on the above subject. He first laid stress on the great variety in the anatomical relations of the frontal sinus and the naso-frontal duct. Hence the difficulties experienced in probing the sinus. The direct cause of these difficulties may be either narrowness or unusual direction of the duct or the obstruction offered by the anterior end of the middle turbinal. If the latter is the cause it must be removed, and this is a comparatively insignificant surgical procedure. Only in unskilled hands could an injury to the cribriform plate occur. He then relates two cases where severe ocular disturbances had arisen as a result of empyema of the frontal sinus and the ethmoid cells. In closing he wished to draw the attention of the profession to the relation which exists between diseases of the accessory cavities and certain amauroses; and advised, in all cases of failing vision, that this relationship should not be forgotten.

VITTUM.

A Case of Fibroma of the Superior Maxilla—JOS. PREINDLSBERGER—*Wiener Med. Wochenschr.*, January 19, 1899.

Preindlsberger reports a case of the above affection which occurred in a Mohammedan woman who applied to him for relief. From its size and situation the tumor gave rise to some disturbance both of respiration and nutrition. The tumor was immovably fixed to the alveolar process just below the upper lip by a pedicle 10 ctm. wide. When the mouth was closed it was wholly covered by the growth which also compressed the nostrils by pushing up the upper lip. The tumor was covered with mucous membrane and seemed firm and hard throughout. It was easily removed, and a section showed it to be a fibroma.

VITTUM.

IV. LARYNX AND TRACHEA.

Persistence of Branchial Clefts—ALFRED ELLIS VAUGHAN—*British Medical Journal*, January 21, 1899.

The author records a case where four members of a family, all females, in three generations, had persistent branchial clefts.

Mrs. M. P., grandmother, one fistula, right side of neck; Miss M. C., granddaughter, two fistulæ, one on either side of neck; Miss A. C., granddaughter, one fistula, left side of neck; Miss F., great granddaughter, one fistula, left side of neck.

FOX-CROFT.

Syringomyelia with Grave Laryngeal Complications—DRUAULT
Revue Hebdomadaire de Laryngologie, etc., September 10, 1898.

A careful description of the symptoms and pathologic lesions of this infrequent complication of syringomyelia.

SCHPEPPEGRELL.

Effect of Foreign Bodies in the Bronchi—R. SEVESTRE—*British Med. Jour.*, Jan. 21, 1899.

A review of the most noticeable changes taking place in the lungs from the effects of foreign bodies in a bronchus, both in the early stages when the lung is collapsed and in the latter stage when the bronchial tubes have thickened walls, are full of secretion and inflammatory changes leading to abscess formation take place.

FOXCROFT.

Complete Bilateral Paralysis of the Recurrent—J. HERZFELD—*Berliner Klin. Wochenschr.*, January 23, 1899.

At a meeting of the Berlin Laryngological Society, Herzfeld demonstrated a specimen obtained from a case of the above affection. These are very rare, not over a dozen being on record. About three years ago slight difficulty in swallowing was noticed. This gradually increased. Three months ago hoarseness appeared, which grew worse until the patient could only speak in a whisper, and even then only with the greatest exertion. The esophageal sound showed an obstruction opposite the bifurcation of the trachea. On laryngological examination it was seen that the cords remained absolutely motionless in the cadaveric position both during phonation and respiration. The glottis was sufficiently large to supply air on ordinary occasions; only during exertion was there slight dyspnea. The patient was unable to cough strongly or to laugh loudly.

The post-mortem showed a large carcinoma of the esophagus, which involved the posterior tracheal wall and completely surrounded both recurrent nerves.

VITTUM.

Chronic Hemorrhagic Tracheal Catarrh—MASSEI—*Archiv. Ital. di Laryngologia*, No. 4, 1898.

This is a morbid entity, which has not heretofore been described, but which the author has observed in a number of cases. The patients appeared frightened, weak and declared that they had been spitting blood. An examination of the chest and larynx revealed nothing abnormal. The trachea, however, gave evidence of recent hemorrhage, and a careful examination showed an area in which there was a perfect vascular network, the varices in each case touching the inferior surface of the vocal cords.

The pathology of the affection and its localization in the subglottic region is explained by the excess of pressure to which this region is subjected by the expired air, particularly during phonation. This causes dilatation of the vessels, which are numerous, and the relaxation of their walls. The prognosis is favorable when the general health is good.

SCHEPPEGRELL.

A Study of Vowels—MARAGE—*Revue Hebdomadaire de Laryngologie, Etc.*, Sept. 17, 1898.

An interesting article on the study of vowels by means of the manometric flames of Koenig.

SCHEPPEGRELL.

Multiple Ecchondroma of the Trachea—VON RECKLINGHAUSEN—

Wiener Med. Wochenschr., January 5, 1899.

At a meeting of the Medical Society of Strassburg, held Dec. 9th, von Recklinghausen exhibited a case of the above affection, and at the same time a recent case of osteoma of the tracheal mucous membrane. The specimen consisted of a host of small bony scales which had coalesced to form a large bony plate presenting numerous sieve-like openings. Notwithstanding their superficial location it was evident that both the chondroma and the osteoma sprang from the deeper lying tissues, namely the perichondrium. VITTUM.

Thyreotomy in Papilloma of the Larynx in Adults—M. T. HÄRDIE

N. Y. Med. Jour., January 7, 1899.

An interesting report of two cases of thyreotomy for laryngeal papilloma in adults. In the first case the growth was removed with scissors, and its point of attachment cauterized, which was followed by uninterrupted recovery.

The second case was removed by the ordinary nasal snare, the base of the growth cauterized with chromic acid. The voice was hoarse, but gradually improved. There were but few attacks of the spasmodic coughing, which had been one of the most severe symptoms of this case. There was no recurrence. SCHEPPEGRELL.

Spasmodic Closure of the Glottis in the Adult—H. STILLSON—

N. Y. Med. Jour., January 7, 1899.

The two cases reported are in line with Bosworth's belief that the attacks of spasmodic closure of the glottis in the adult occurring in the day time, especially when exhibiting permanent paralysis or paresis of one or more of the laryngeal abductor muscles, indicate a central nerve lesion, while these attacks occurring at night and not manifesting permanent impairment of motility in the abductors, may be judged purely reflex in character. SCHEPPEGRELL.

Treatment of Laryngeal Phthisis—R. LAKE—*Jour. L., R. et O.*,

February, 1899.

The local treatment of this affection is divided into surgical and non-surgical.

Six clinical heads are suggested as a classification:

1. A granular condition of the vocal cords.
2. Superficial excoriation or ulceration.
3. Edema.
4. Edema and superficial ulceration.
5. Deep ulceration.
6. Mixed edema and deep ulceration.

In classes 1 and 2 intratracheal injections have proven very efficacious.

In cases where swelling or edema alone was present, or where the ulceration was limited, the topical application of drugs was

confined to paints. Surgical assistance, however, gives the best results in this class. The infected tissues should be freely removed with curette or forceps. Formic aldehyde or lactic acid should be used after every intra-laryngeal operation upon a tubercular subject, no matter how small the operation performed.

When the larynx is extensively ulcerated the patient's general condition will not permit of heroic measures. In such cases insufflations of iodoform and orthoform exert a soothing and often partly curative effect.

Dysphagia with existing ulceration is satisfactorily relieved by the application of orthoform. This drug is a non-toxic anodyne.

For intra-tracheal injections he advises naphthaline treated with an emulsifying agent, lanoline 3 per cent. LEDERMAN.

A Case of Chronic Urticaria of the Larynx—W. FREUDENTHAL—*N. Y. Med. Jour.*, December 31, 1898.

A number of cases of acute urticaria of the larynx have been reported, but this is the first case of chronic urticaria, according to the author, which has been described. The symptom was associated with obstinate urticaria of the skin. The herpetiform prominences with edematous surroundings and other prominent symptoms gave evidence of the neurotic character of the disease, and justified the author in his diagnosis. SCHEPPEGRELL.

V. EAR.

Errors Observed in Oto-Laryngologic Work; their Results and Remedies—M. A. GOLDSTEIN—*Med. Herald*, Vol. xviii, No. 2, February, 1899.

In this article the author indicates by practical illustration, some of the careless and culpable errors which are frequently met with in the practice of Oto-Laryngology. Two cases of foreign body in the ears of children, where a physician had used vigorous efforts to remove the substances and seriously damaged the deep structures, leads him to conclude that: "First, the removal of a foreign body from the external auditory canal should not be attempted without proper and delicate instruments and should not be undertaken by inexperienced persons.

Second, in the removal of foreign bodies from the ear where the mass is firmly impacted or tightly held by the narrow confines of the canal, and where some difficulty in the removal of the same is anticipated, the most advisable procedure to prevent restlessness on the part of the patient with movement of the head and possible injury to the parts during the operation, is a moderate chloroform narcosis."

In another case the patient had been treated in a local medical institute for aural suppuration. Facial paralysis ensued, and a prognosis of "threatened apoplexy" made at the "institute." The removal of a large polyp and proper treatment of the tympanum

promptly cured the facial paralysis which was complete, and apparently due to pressure of the growing granulation polyp on the corda tympana nerve.

Another example of criminal carelessness is recounted where the patient presented himself with syphilitic lesions clearly traced to the system of treatment in an "institute," consisting in placing the patients in a row and spraying them successively with the same atomizer and the same solution.

The great difficulty experienced in attempting to check nasal hemorrhage in a case presenting the hemophilic diathesis, is illustrated by the history and treatment of a man so afflicted, and the author points out that "It should be an object lesson to many who regard nasal hemorrhage, traumatic or spontaneous, as of slight importance, and who frequently treat this condition indifferently, to carefully question every patient as to a hemophilic predisposition."

EATON.

Otological Remarks—DUNDAS GRANT, London—*Jour. L., R. et O.*, February, 1899.

The author's remarks are based upon Mr. Arthur Cheate's paper, "Operative Interference on the Drum and Ossicles in Chronic Middle Ear Suppuration." Mr. Cheate's paper represents a reasonable average conclusion of various authorities upon this important subject.

Operation is chiefly called for when the discharge persists after careful local treatment, and when the perforation is situated in Shrapnell's membrane, or in the postero-superior quadrant of the drum. The chief cause of attic suppuration is attributed to caries of the head of the malleus, body of the incus or both; caries of some part of the attic walls; collections of cholesteatoma; inspissated pus or granulation tissue. Mr. Cheate has obtained excellent results from the removal of the outer wall of the attic. The removal of the ossicles and remains of the membrane is recommended by most otologists when caries of the ossicles exist, or when they act as an obstruction to drainage.

When the opposite ear is normal ossiculectomy is not advisable. Dr. Grant believes, however, that with experience and improved technique it will be judicious to operate upon a chronic suppurating ear, and thus avoid the possibility of "sympathetic nerve-deafness." If the ear shows signs of diminished function, the question of radical interference in the diseased ear must be urgently considered.

Professor Politzer lays stress upon this counter-indication: "That ossiculectomy should not be performed for the improvement of the hearing-power in an ear by which whispered speech can be heard at the distance of about one meter.

Dr. Grant does not countenance ultra-tympanic surgery in typical chronic sclerotic disease of the middle ear, but he believes that the prospects are totally different in the post-suppurative condition, when the internal ear is fairly intact.

LEDERMAN.

Congenital and Acquired Deformities of the Ear—STETTER—*Klinische Vorträge aus dem Gebiete der Otologie und Pharyngo-Rhinologie*, II Band, 9 Heft, 1898.

This monograph deals at length with the congenital abnormalities of the external ear. The various defects are noted and the operations devised for their removal are described. Absence or occlusion of the external auditory canal is most generally accompanied by structural defects in the middle and internal ear, so that an operation is usually fruitless. The middle ear is sometimes completely filled with bony growth so that it is, in fact, obliterated. Deformity of the drum-head alone is very rare and those cases of reported congenital perforation are to be looked on with suspicion, as pathological processes may bring about this condition very early in life.

Abnormalities of the ossicles and of the muscles attached to them are of rather frequent occurrence. Quite a number of cases are reported where the Eustachian tube is said to have been very much altered in its calibre, even to the point of obliteration. But so experienced an aurist as Gruber affirms that these defects are the result of early disease, perhaps even of intra-uterine inflammation.

The cavities of the mastoid vary so widely, and that within the bounds of normality, that it is very difficult to point out an undoubted deformity. The defects of the internal ear are largely influenced by heredity. The structures may be absolutely wanting. Again, the cochlea may present a varying number of spirals. The semicircular canals may be wanting in whole or in part. They may be dilated or narrowed. The aqueductus vestibuli may be enormously dilated or it may exist in duplicate.

The acquired deformities of the external ear may take on almost any form as a result of phlegmonous inflammation, or of perichondritis. The author reports a case where all of the cartilages seemed to have undergone ossification.

Haug has recently reported a case of elephantiasis. The affected ear measuring $12\frac{1}{2}$ ctm. in length, 7 ctm. in breadth and 23 ctm. in circumference, while the corresponding measurements of its fellow were 5, $3\frac{1}{2}$ and 10 ctm.

The most important deformities of the external ear are those which result in atresia of the canal. This may result from burns or any inflammation that is followed by much scar tissue. Wounds of various kinds, particularly those resulting from unskillful attempts at extracting a foreign body, may lead to atresia.

In the drum-head the most common abnormality is the perforation, although thickenings and scars are frequently met with.

In the middle ear all kinds of changes and defects—even to total destruction—may result from chronic inflammation or tumors; and the same may be said of the internal ear.

VITTM.

Tinnitus and Noises of the Ear—BOUCHARD—*Revue Hebdomadaire de Laryngologie, Etc.*, Sept. 17, 1898.

Tinnitus of high pitch is observed in active or passive hyperemia of the auditory organ when the labyrinth is also involved. Tinnitus of low pitch in the majority of cases is of nervous origin, especially in cerebral tumors, affections limited to the labyrinth, and affections of the middle ear with participation of the nervous apparatus. Entotic sounds are observed when the condition of the resonance of the ear is especially favorable (obstruction of the canal, secretions in the tympanum) and when there is hyperemia of the acoustic nerve.

Melodious sounds are a rare phenomena and are due to the excitation of the encephalum. Noises of the ear may be of a reflex character as in neuralgia of the trigeminus, dental neuralgia, glaucoma, migraine, affections of the uterus, stomach, kidneys, liver, and are also the tinnitus of neurasthenia and hysteria. Noises may exist which are compatible with the integrity of the auditory apparatus, such as muscular sounds, sounds due to the rubbing of the temporo-maxillary articulation, etc.

The author recommends the use of quinine, which at first increased and afterwards diminished the tinnitus, not only in the dry and sclerotic form, but also in Menière's disease.

SCHEPPEGRELL.

Noises in the Ear Treated with Cimicifuga—SETH SCOTT BISHOP, Chicago—*North American Practitioner*, January, 1899.

The author refers to the article by Robin and Mendel, which lately appeared in *La Medicine Moderne*, and suggests that cimicifuga may act by restoring the normal tension to the ossicular chain. A number of cases are cited in which cimicifuga gave marked relief in tinnitus, especially that resulting from hypertrophic otitis media. In some cases the hearing was improved. The dose given was from twenty to thirty drops daily, in divided doses if headache was produced.

ANDREWS.

Otitis Media Purulenta Chronica—CHEVALIER JACKSON—*Journal of the American Medical Association*, January 28, 1899.

Jackson lays especial stress upon thorough methods of cleansing the ear in suppuration, particularly in syringing with sterilized water and other agents. His first step in the treatment is to cleanse the auditory canal as thoroughly as possible, and drying it with a mop of cotton on an applicator. Then he applies hydrogen dioxide with a mop of cotton and wipes out the canal again. Next he syringes with a warm solution of hydrogen dioxide and then irrigates with warm sterilized water. Finally he dries out the meatus, and, if there still remain any debris, he insufflates a finely powdered digestive powder, such as carica papaya, the South American digesting melon. This routine is repeated daily until the ear is thoroughly clean.

MCLEAN.

Suppuration of the Middle Ear, Complications and Consequences, Etc.—A. D. McCONACHIE—*Maryland Med. Jour.*, Jan. 21, 1899.

The anatomical relationship of the organ is practically described. Attention is directed to the pathological changes which follow an infectious process. The close relation of the tympanic and cranial cavities is dwelt upon. Extension of suppurated disease to the labyrinth is mentioned. Caries of bone should be suspected when polypi and granulation tissue are present. The complications which may arise are noted, but not in detail, as the article is to be continued in another issue.

LEDERMAN.

Cholesteatoma of the Ear—RUDOLF PANSE—*Klinische Vorträge aus dem Gebiete der Otologie, etc.*, II Band, 4 Heft.

This is an excellent paper on the vexed question as to the etiology of Cholesteatoma. The author vigorously defends the view that the epithelial "pearls" come about in a perfectly natural way as the result of antecedent inflammation, the extension of pavement epithelium into the middle ear, and, later on, inadequate means of escape as it is thrown off. Fully two-thirds of the monograph is taken up in going over this matter in the most careful and painstaking manner. The latter part of the paper dealing with examination, symptoms, prognosis, etc., contains nothing new. Under the head of treatment, the author insists upon the importance of operating in such a manner that the suspected cavities may always be under control of the eye. If a careful ocular inspection can be made, the earliest symptom of a relapse may be noted.

VITTUM.

The Manner in which the Mastoid becomes Involved in Middle Ear Inflammations—J. E. SHEPPARD—*Brooklyn Med. Journ.*, March, 1899.

The normal condition is such that any secretion forming in the mastoid antrum should pass through the aditus into the attic, thence to the tympanic cavity proper, through the Eustachian tube into the naso-pharynx. The motion of the cilia on the tubal epithelium favoring such a result.

Under abnormal conditions the tube may be forcibly opened and foreign matter with disease germs may eventually find their way into the mastoid antrum. In infectious diseases sepsis frequently extends from the naso-pharynx.

Congestion and inflammation affecting the mucous membrane, which exists in folds and reduplications in the middle chamber, quickly close up the natural passages and thus causes a retention of secretion. The tension of confined pus in this region is very great. There are ten sets of cells in the mastoid. The *horizontal*, including the antrum, which readily empty their contents into the antrum, and the *vertical set*, which extend downwards toward the mastoid apex.

When pus does not extend beyond the antrum, and the infection is not too virulent, the case may get well without opening the mastoid, providing the middle ear is well drained.

The mastoid cortex may be thick and the local symptoms in this particular region may be absent. Consequently we must not prolong expectant treatment.

In acute inflammation of the middle ear the streptococcus and pneumo-diplo-coccus is most frequently found. In chronic suppuration, the staphylococcus is present.

LEDERMAN.

Cocainization of the Semicircular Canals—CHARLES J. KOENIG—*Wiener Med. Wochenschr.*, Jan. 12, 1899.

In a paper on the above subject read before the Physiological Club of Vienna, Koenig reaches the following conclusions:

1. Along with Crum-Brown, Breuer, Delage and others, he is of the opinion that the semicircular canals are the organ for the sense of rotation. They notify us as to all active motions of rotation, either of the head alone, or of the body. They, however, do not give us any information as to passive rotation movements, if these last are prolonged and in one direction.

2. Inasmuch as all active movements which effect a change of position of the body are wavelike in form, the semicircular canals keep us informed as to all movements which we make as a whole, and are therefore to that extent the organ of equilibrium.

3. Through their relation to movements that are effected, they can keep us informed as to the comparative situation of the head with reference to the body, and as to the situation of the body with reference to its surroundings.

4. The canals of the left side are more sensitive to rotation movements toward the left than toward the right, and *vice versa*.

5. Irritation of the semicircular canals as well as anesthesia interferes with their function.

6. The semicircular canals are not the organ of the sense of space.

VITTUM.

Tuberculosis of the Ear—KRETCHMANN—*Münchener Med. Wochenschr.*, January 3, 1899.

At a meeting of the Magdeburg Medical Society, held November 3d, Dr. Kretschmann read a paper on the above subject. He states that tuberculous processes in the outer ear or the external meatus differ in no respect from those affecting the skin in general. Those processes located in the middle ear, however, possess a more individual character and may be divided into three groups. In those of the first group one can see, in favorable cases, miliary nodules in the substance of the tympanic membrane. As a rule, however, these have already degenerated at the time of the first examination, and one sees a number of perforations which rapidly coalesce and lead to a total loss of the drum-head. The mucous lining of the tympanum is thickened, of a yellowish red color, and gives evidence of ulceration. The onset and course are painless. This

form is found in persons who have been rendered cachectic by tuberculous processes in other parts of the body, and are approaching the end. The second type is developed in individuals suffering from tuberculosis, but who still possess considerable power of resistance. Along with a feeling of fullness and a diminished hearing power there is a discharge from the ear. The perforation which is at first present is soon filled with granulations which rapidly increase and fill up the tympanum and its accessory cavities, destroy the drum-head, cause exfoliation of the ossicles, and sometimes break through into the labyrinth or the cranial cavity; erosion of the internal carotid or the jugular vein, and paralysis of the facial nerve may follow. The third form is generally grafted upon a pre-existing chronic purulent inflammation and appears as a circumscribed necrotic spot generally seen on the labyrinthine wall. It may readily be mistaken for a fibrinous deposit, but is a diseased condition of the tissues themselves. Tubercle bacilli can generally be found and the probe often reveals rough bone. The process may long remain stationary. The diseased spots are gradually covered with granulations; these shrink and a renewal of the epithelial covering is begun. This form occurs in those who are just becoming infected with tuberculosis or who inherit it. The treatment may at first be confined to the use of iodoform or balsam of Peru, but these failing, nothing short of destruction of the tuberculous tissue will suffice. If the process is limited, the application of caustics through the external canal may succeed. If the tympanic cavity has been invaded, all the cavities connected with the middle ear must be opened. General treatment must accompany the local.

VITTUM.

A Symptom of Endomastoiditis with Empyema—BARRAGOCIARELLA—*Jour. L., R. et O.*, January, 1899.

In two-thirds of the cases operated on by Cozzolino in his clinic, the procedure was justified by the condition found, while the symptoms, both in general and local aspects, failed to indicate surgical interference. The "unique symptom" mentioned by Cozzolino is the speedy reappearance of pus in the tympanic cavity, after same has been cleansed. The author of this article states that in six cases observed by him "Cozzolino symptom" was the only, but unfailing, indication of pus in the mastoid.

LEDERMAN.

An Improved Ear Trumpet—KUGEL—*Revue Hebdomadaire de Laryngol., etc.*, October 8, 1898.

The author has designed a trumpet on the principle of the ear of the horse, like which it is shaped, instead of the usual large flaring rim, to concentrate the sounds. This shape obviates the annoying resonance of the ordinary trumpet, especially as there is a number of holes pierced in the conducting tube. Gruber and Politzer endorsed the new trumpet at a recent meeting of the Austrian Society of Otology. Bing also suggested that as the sounds collected by the receiver are all transmitted to the ear together, instead of being

concentrated as when light is focused, the tube that conveys the sounds from the receiver to the ear should be as large as possible, with no space wasted. He, therefore, suppresses the tube altogether and applies the receiver directly to the entrance of the auditory canal, thus securing a fuller tone, and intends to supplement the instrument with a hollow plate over the mastoid apophysis, to promote osseous conductivity.

SCHEPPEGRELL.

Disturbance of Equilibrium Associated with Defect of Hearing—Labyrinthine Vertigo (Meniere's Disease.)—P. W. ERDMANN—*N. Y. Med. Jour.*, January 28, 1899.

The treatment consisted of pilocarpin and quinine alternated with large doses of bromide containing a few minims of belladonna. The case terminated with a cure.

SCHEPPEGRELL.

VI. DIPHTHERIA, THYROID GLAND, ESOPHAGUS, ETC.

Differential Diagnosis of Pharyngeal Syphilitic Lesions and Diphtheria—L. S. SOMERS—*Philadelphia Med. Jour.*, January 28, 1899.

After referring to the well recognized lesions characteristic of each, the author states that in syphilis the patches on the pharynx and tonsils are not so elevated. The adjacent tissues are not so violently inflamed. The crucial test, bacteriologic examination, however, is the best method in diphtheria.

SCHEPPEGRELL.

Notes on the Treatment of Diphtheria—THOS. WYLD FAIRMAN—*Australasian Med. Gazette*, Vol. xvii, No. 12, December, 1898.

The writer points out certain elements of treatment which appear to him of importance: *Rest* is essential even in comparatively mild cases. Since the routine use of gargles has been abandoned the number of pharyngeal paralyses has lessened. Applications locally should be as unirritating as possible, the resistance of excitable children causing a nervous condition inimical to recovery. *Local Medication*—This is called for even when antitoxin has been used, since there is often a multiple infection on which it has no effect directly. To be of any use medicaments must reach well behind the tonsil, hence those which can be swallowed are most satisfactory. *Free Diuresis*—This is mentioned in all works on the subject, but recent pathology has demonstrated its eminent importance. The free use of diluents is therefore essential, more especially if antitoxin has not been used.

Antitoxin—The value of this is undoubted, but it should be administered before the third day. *General*—If antitoxin has been used late, or not at all, when there is multiple infection, or when the larynx is involved, much benefit is derived from the bronchitis kettle kept going constantly in the room.

EATON.

Diphtheritic Laryngitis—Intubation—E. D. CAPP—*Texas Med. News*, January, 1899.

A clinical report of three cases, from a study of which the author concludes that there is no comparison between intubation and tracheotomy in these cases; the latter should never be done unless there is some special reason why intubation would not prove successful; intubation with diphtheritic antitoxin makes the prognosis favorable. The tube should be introduced before cyanosis appears, in fact, as soon as the breathing becomes labored. Antitoxin should be given early in the disease, not waiting for distressing symptoms to arise.

SCHEPPEGRELL.

A Case of Severe Hemorrhagic Diphtheria with marked Membranous Development—H. BATTY SHAW—*British Med. Jour.*, Jan. 21, 1899.

Patient, a well nourished girl, aged nine years, was admitted to the University College Hospital Nov. 16, 1897, suffering from difficulty in breathing. Laryngotomy was performed and she died eight or nine hours after being relieved.

The case is interesting from the likeness it bore in the earlier stages to ordinary severe quinsy and from the peculiar appearance of the mouth, it being impossible to define the faucial aperture, the space being occupied by a black sloughy mass which rested close on the tongue so that neither tongue, tonsils nor pharynx could be seen.

The necropsy showed the appearance in the mouth to be due to a very thick diphtherial membrane closely adherent to the soft palate, but merely overlaying the hard palate without being attached to it. The soft palate was remarkably thickened owing both to the edema of the tissues and to the existence of diphtherial membrane, being two-thirds of an inch thick. The pharyngeal wall was greatly thickened, in part by membranous deposit and in part by extravasated blood. Sections were made of the infrahyoid muscles and the muscle fibers were widely separated by blood which in places had torn the muscles across.

Bacteriological culture showed the diphtheria bacillus.

FOXCROFT.

Anatomic and Clinical Study of the Respiratory Passages and their Annexes by the Roentgen Rays—MAURICE MIGNON—*Gazette des Hôpît.*, No. 102, 1898.

This method permits of the examination of the peri-tracheo-bronchial glands, which is frequently difficult by the ordinary methods; of foreign bodies in the lungs, as well as congestion, edema, emphysema, pneumonic, cancerous or tuberculous areas, the limits of hydatid cysts, and finally of alterations of the pleura and modifications of its cavity. The author considers the fluoroscope a valuable addition to the ordinary methods of examination.

SCHEPPEGRELL.

Treatment of Exophthalmic Goitre—KANT—*Revue Méd.*, December, 1898.

The following is recommended:

R. Sulphate of duboisine..... $\frac{1}{120}$ grain
Water..... 30 minims

M. To be taken twice or three times daily.

As the drug sometimes produces somnolence and inebriety, the effect should be carefully watched. SCHEPPEGRELL.

Thymus Extract in Exophthalmic Goitre—W. RUSHTON PARKER
—*British Medical Journal*, January 7, 1899.

The author publishes accounts of four cases of exophthalmic goitre, with photographs of the patients, treated with Thymus extract, and in three of the cases the patients ate largely of lightly cooked lambs' thymus glands. In all the cases the patients improved, but the record will hardly allow the improvement to be definitely traced to the administration of the Thymus extract.

FOXCROFT.

The X-Rays in the Diagnosis of Tuberculosis—ANTONIO ESPINA Y CAPO—*Revista de Med. Cir. Prácticas*, November 25, 1898.

The author states the following as the result of his researches:

1. Radiography is a means especially suitable for the early diagnosis of tuberculosis, the study of which should be cultivated by all specialists.

2. There are now data sufficient to diagnosticate by the *tout ensemble* of the radiograph between tuberculosis and the neoplastic conditions of the lungs, but especially to limit the zones invaded by the affecting processes.

3. In pleuritic effusions it is the best and most certain method of diagnosis, especially for the purpose of defining the upper level of the effusion.

SCHEPPEGRELL.

Treatment of Tuberculous Adenitis of the Neck by the Roentgen Rays—HENDRIX—*La Polyclinique*, December, 1898.

The author obtains encouraging results from radiography in scrofulous glands. When the latter are fused together and before caseation has taken place, the rays seem to isolate them, they become mobile, smaller and firmer. If, however, caseation has begun, the rays have a distinctly irritating effect, and will aggravate the disease, and are therefore contraindicated. The author seems to believe that the rays destroy the bacillus, but he apparently made no attempt to verify his theory by excision. SCHEPPEGRELL.

VII. INSTRUMENTS AND THERAPY.

New Instrument—MAX BREITUNG—*Münchener Med. Wochenschr.*, January 10, 1899.

In a short communication the author describes a new instrument for tonsillotomy. This consists of a blade cutting from behind forwards and operated by a wire drawn through the canula of a Krause's snare. Breitung calls it a resectome for the tonsils and says that he uses it principally for removing the "lips" that form after the operation of splitting up the tonsil.

VITTUM.

New Instruments—L. KATZ—*Berl. Klin. Wochenschr.*, January 30, 1899.

In an article published as noted above the author describes three new instruments. The first, an adjustable curette for the posterior end of the lower turbinal. This is so arranged that after the introduction of the instrument, the curette may be brought up so as to form an obtuse angle with the handle; thus giving a good purchase on the tissue to be removed. Katz advocates its use principally in those cases where the posterior swelling is small and hard, and therefore difficult to seize with a snare.

The second instrument is an adjustable caustic carrier for cauterizing the posterior end of the lower turbinals. It consists of a minute shallow plate attached to the handle by a joint. This plate can be flexed to any angle by means of a trigger device at the opposite end of the handle. The caustic, either nitrate of silver or chromic acid, is to be melted on the plate, which is of pure silver, and carried in opposite the point to be cauterized. The trigger is then pressed down and the plate with its contents thus pressed against the tissue to be destroyed.

The third instrument is a cauterizing probe for the ear and nose. It is much like an ordinary nasal probe except that it has a minute crown-shaped attachment made of gold. This little ring with its fine saw-like teeth secures a much firmer hold on the molten "pearl" of chromic acid, or silver nitrate, than the usual rounded head of a probe.

VITTUM.

The Treatment of Hyperemic Laryngitis by means of a Ten per Cent Solution of the Suprarenal Gland—SARGNON—*Lyon Med.*, Oct. 2, 1898.

In six cases reported, the effect of the solution as a vaso-motor constrictor was demonstrated.

[In discussing this subject, Dr. Brindel (*Revue Hebdomadaire de Laryngologie*, Nov. 26, 1898,) states that if the application of the suprarenal gland causes contraction of the vessels it is of such a transient character as to be of no value. In his own experiments he found neither a blanching of the mucous membrane nor anesthesia, and the effects were more disagreeable than otherwise.—W. S.]

SCHPEPPEGRELL.

A Mixture for Coryza—MALBEC—*Riforma Medica*, January 17, 1899.

℞ Extract of hyoscyamus	2¼ grs.
Iodide of potassium,	
Bicarbonate of potassium	aa 30 "
Extract of licorice	75 "
Anise water	1800 "

M. A tablespoonful every four hours.

SCHEPPEGRELL.

A Local Application for Nasal Ulcers in Ozena—A. FASANO—*Archiv. Int. di Med. e Chir.*, November 30, 1898.

The author recommends for topical use in the more or less deep ulcerations that are found in inveterate ozena the following:

℞ Aristol	150 grs.
Collodion	1200 grs.
Castor oil	150 grs.

M. The application should be made daily by means of small cotton holders.

SCHEPPEGRELL.

The Treatment of Recurrent Epistaxis—RENDU—*Riforma Medica*, January 10, 1899.

℞ Antipyrine	7½ grs.
Tannin	15 "
Powdered sugar	150 "

To be used locally.

SCHEPPEORELL.

Some Remarks upon the Use of the Supra-Renal Gland of the Sheep in Nasal Surgery—C. L. VANSANT, Philadelphia—*Phila. Med. Journ.*, February 25, 1899.

This desiccated extract has proven a valuable addition to the therapeutic resources of the rhinologist. It greatly increases the anesthetic effect of cocain and eucain, and produces a marked ischemia when applied alone. The only disadvantage which watery solutions of this remedy possess is that they soon become putrid.

To remedy this defect the author prepares a fresh solution of the gland daily. He employs five grain capsules of the gland, and employs the following mixture as a menstruum:

℞ Acid boraci	gr. xi
Aq. camph.,	
Aq. destillat.	aa ʒss

He puts one drachm of the above in a two-drachm bottle, adds the contents of one capsule, shakes the mixture thoroughly, then filters and the solution is ready for use. A saturated solution of boracic acid is also serviceable. He mentions a glycerine extract of the fresh gland, made by Mr. F. C. Morgan, of Philadelphia. In that preparation 100 minims are said to represent 67½ grains of the fresh gland.

The process of preparing the glycerine extract must be carefully performed, so as to produce a pure and clean product. This latter preparation can be kept for a long period. Ten drops of this extract (glycerine) added to one drachm of the boric-camphor solution and well shaken is ready for use.

LEDERMAN.

The Treatment of Epistaxis—MARC HADOUR—*Revue Int. de Med.*, Etc., September, 1898.

The author does not use the electro-cautery, which he considers difficult, nor the nitrate of silver, which leaves too soft and superficial an eschar. He prefers chromic acid, a pearl of which is melted on the end of a probe and applied to the bleeding spot.

[Very few men of experience will question the superiority of the electro-cautery over chromic acid for epistaxis. The article does not refer to the advantage of packing with iodoform gauze in such cases.—W. S.]

SCHEPPEGRELL.

Creasote in Ozena—FERRARI—*Riforma Medica*, January 10, 1899.

R Creasote.....	75 grs.
Alcohol at 70 per cent.....	150 "
Glycerin	600 "

For application on alternate days.

SCHEPPEGRELL.

Application to the Throat in Whooping Cough—*Tennessee Med. Jour.*, January, 1899.

A local application of a ten per cent solution of citric acid in simple syrup is recommended in this affection. Small quantities of citric acid lemonade frequently given is said to act beneficially both as a prophylactic and curative agent.

LEDERMAN.

A New Method of Local Anesthesia in Operations on the Tympanum and Tympanic Membrane—BONAIN—*Revue Hebdomadaire de Laryn et Otol.*, Nov. 29, 1898.

The author has obtained good effects from the following formulæ:

R Phenol	2 grammes
Menthol	1 gramme
Chlorhydrate of cocain.....	1 gramme

OR

R Phenol
Menthol
Chlorhydrate of cocain.....	aa 1 gramme

After sterilizing the auditory canal, the anesthetizing agent is applied by means of a pledget of absorbent cotton. In the cases in which it was used there was at first a light burning sensation which was followed by complete local anesthesia in three minutes.

SCHEPPEGRELL.

Open-Air Treatment of Consumption—A. TUCKER WISE—*N. Y.**Med. Journ.*, January 14, 1899.

In discussing the value of the open-air treatment of tuberculosis, the author frequently quotes from the work of the late Dr. George Bodington, of Sutton Coldfield, Warwickshire, who was the first to devise and carry out the present system of generous diet and open-air exposure for the cure of this disease.

SCHEPPEGRELL.

A Note on the Suprarenal Capsule—J. H. THOMPSON—*Kansas City**Med. Record*, Vol. xvi, No. 2, February, 1899.

In cases of chronic otorrhea, Thompson finds that where, after washing out the canal, the fundus appears filled with granulations, the membrana swollen and the tympanic cavity occluded by a red and thickened mucosa, the external canal is filled with five grains of the pulverized desiccated suprarenal capsule of the sheep prepared by Armour & Co., Chicago, dissolved in two drams of water, the granulations will disappear (!) at once, the swelling of the mucosa diminish, and the hole in the membrana and the cavity of the middle ear become opened up.

EATON.

Iodole-Menthol in Throat and Nose Affections—*Merck's Archives*,

January, 1899.

This preparation is said to be a mixture of iodole with one per cent of menthol. It is calculated to be of special service in the treatment of catarrhal and ulcerous affections of the nose and throat, employed in the form of insufflations. The iodole action is present in marked degree.

LEDERMAN.

Hygiene versus Drugs in the Treatment of Pulmonary Tubercu-**losis**—CHAS. L. MINOR—*N. Y. Med. Journ.*, January 14-21, 1899.

"No man can treat phthisis long and not realize that nothing which in the least degree upsets the stomach, that very citadel of the consumptive's defenses, can, whatever its theoretical advantages, be anything but a curse to his patient." In this thorough communication the author demonstrates the truth of his text, the value of "hygiene versus drugs in the treatment of pulmonary tuberculosis."

SCHEPPEGRELL.

Orthoform—*Merck's Archives*, January, 1899.

A new form of this drug has been described by Klaussner. It is an evenly fine powder, white in color and cheaper than the old preparation. It is recommended in laryngeal ulcerations, and in hay asthma. It produces anesthesia lasting from eighteen to thirty-six hours. Orthoform is not poisonous.

LEDERMAN.

BOOK REVIEW.

Diseases of the Ear, Nose and Throat and their Accessory Cavities.

By SETH SCOTT BISHOP, M.D., D.C.L., LL.D. Professor of diseases of the Nose, Throat and Ear in the Illinois Medical College, Professor in the Chicago Post-Graduate Medical School and Hospital: Surgeon to the Post-Graduate Hospital, Associate Editor of *THE LARYNGOSCOPE*, etc. SECOND EDITION. Thoroughly Revised and Enlarged. Illustrated with Ninety-four Chromo-Lithographs and Two-Hundred and Fifteen Half-tone and Photo-engravings. $6\frac{1}{2} \times 9\frac{1}{2}$ inches. Pages xix-554. Extra Cloth, \$4.00 net; Sheep or Half-Russia, \$5.00 net. The F. A. Davis Co., publishers, 1914-16 Cherry street, Philadelphia.

In the review of the first edition of this excellent volume we have expressed the opinion that as a reference manual, both to the specialist and general practitioner, to the post-graduate and to the medical student, this is the most thoroughly practical and serviceable American publication in the recent literature of otology, rhinology and laryngology.

The second edition enhances the worth of this volume in many directions. One of the most valuable features of this work is the unusually large number of excellent and original illustrations and cuts to elucidate the text. The subject matter is concise and offers no unnecessary data and is therefore especially adapted to the needs of the medical student and general practitioner. As the volume is thoroughly up-to-date it should also engage the attention of the active worker in the trio of specialties which it represents.

Among the new features of the second edition we would especially note two new chapters, one on "Related Diseases of the Eye and Nose" and the other on "Life Insurance Affected by Diseases of the Ear, Nose and Throat." A consideration of "Direct Laryngoscopy and Autoscopy and Pachydermia Laryngis," profusely illustrated, have been added.

The quick disposal of the first edition is perhaps the best endorsement which this volume can receive and we predict an equally ready sale for successive issues.

An American Text-Book of Diseases of the Eye, Ear, Nose and Throat.

Edited by G. E. DE SCHWEINITZ, A.M., M.D. and B. ALEX. RANDALL, M.A., M.D., Ph.D. Royal octavo volume, 1,252 pages, illustrated with 766 engravings, 59 of them in colors. Cloth, \$7.00; sheep or half morocco, \$8.00 net. W. B. Saunders, 625 Walnut street, Philadelphia, publishers. (Can also be obtained of L. S. Mathews, 714 Pine street, St. Louis.)

Since the publication of Burnett's *System of Diseases of the Ear, Nose and Throat* no text-book in oto-laryngology, of a classic character, produced by the collaboration of many prominent specialists has made its appearance. The American Text-Book of Diseases of the Eye, Ear, Nose and Throat is a thoroughly classical publication as far as pertains to its exhaustive chapters, the up-to-date character of its subject matter and the prominence of its contributors.

We incline to the opinion, however, that the combination of oto-laryngology with ophthalmology in one volume is unsatisfactory. This grouping of specialties may be a valuable feature in a volume of lesser magnitude, intended rather for the general practitioner and medical post-graduate. Naturally otology, rhinology and laryngology are intimately associated, not only in the literature of this field, but also in practical work; ophthalmology, however, is a distinct medical specialty, independently represented in literature and in practice. The co-relation of diseases of the ear, nose and throat with diseases of the eye could, perhaps, have been conveniently expressed in one chapter devoted to that subject.

There has been a very commendable selection of authors in the preparation of chapters, with which they are especially familiar, and in which they have rendered distinguished and original work.

As a whole the American Text-Book of Diseases of the Eye, Ear, Nose and Throat is one of the most valuable American additions to oto-laryngologic literature.

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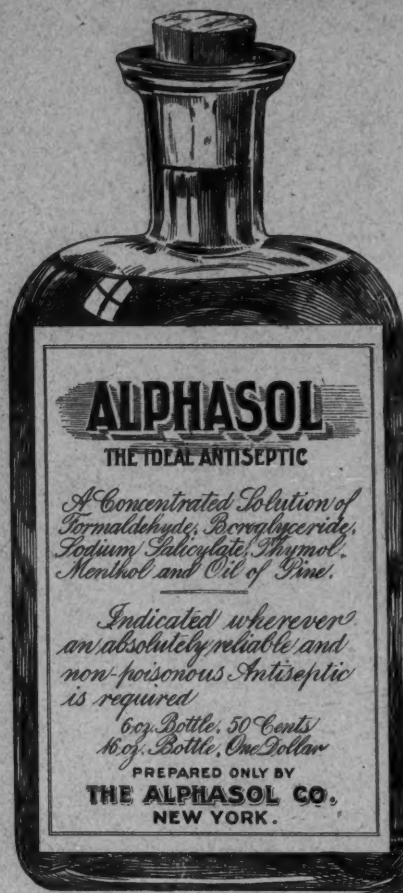
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